

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 6 HOURS		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL OAKLAND		d. STREET ADDRESS 11-2		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MOURY OWEN BAKER		4. DATE OF DEATH OCTOBER 21 1966		5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 15, 1921		9. AGE (In years last birthday) 45 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GENERAL REPAIRS		10b. KIND OF BUSINESS OR INDUSTRY REMODELING		11. BIRTHPLACE (State or foreign country) W. Va. (BLUEFIELD)		12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME HENRY CLAY BAKER		14. MOTHER'S MAIDEN NAME MAUDE LIONS		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNKNOWN	
16. SOCIAL SECURITY NO. 8254		17. INFORMANT THELMA HUTZEL BAKER R.D. OAKLAND, MD.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RUPTURED AORTA DUE TO (b) (AUTO ACCIDENT) DUE TO (c) (AUTO ACCIDENT)		INTERVAL BETWEEN ONSET AND DEATH 9 1/2 HOURS		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> DRIVER IN ONE CAR ACCIDENT	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) DRIVER IN ONE CAR ACCIDENT		20c. TIME OF INJURY Month, Day, Year 6:00 p.m. OCT. 20 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. # 219		20f. (City or town) (County) (State) NEAR BOYNTON, SOMERSET, PA.		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED OCTOBER 21, 1966	
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		M.O. CUMBERLAND, MD.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT. 26, 1966		23c. NAME OF CEMETERY OR CREMATORY OLIVE BRANCH CEMETERY	
23d. LOCATION (City, town or county) (State) PORTSMOUTH, VIRGINIA		24. FUNERAL DIRECTOR JOHN J. HAFFER		ADDRESS 230 BALTO. AVE. CUMBERLAND, MD.		25a. REC'D BY REGISTRAR OCT 26 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		26. DATE OCT 26 1966		27. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

13468

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13463

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 4 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) VCUMBERLAND		d. STREET ADDRESS 285 McMullan Hwy.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH R. BARNARD		4. DATE OF DEATH Month Day Year 10- 2 19 66	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-24-89
9. AGE (In years last birthday) yrs. 77		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist		11b. KIND OF BUSINESS OR INDUSTRY Textile	
11. BIRTHPLACE (County & State, or foreign country) ALLEGANY, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM BARNARD		14. MOTHER'S MAIDEN NAME EMME E. (GABLER) BARNARD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNKNOWN Yes War 1		16. SOCIAL SECURITY NO. 214-07-1882	
17. INFORMANT PATIENT'S CHART		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion (myocardial infarction) 2865 DUE TO Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Malnutrition (b) (c) INTERVAL BETWEEN ONSET AND DEATH 1 week unk			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/29 , 19 66 , to 10-2 , 19 66 that (I) (we) last saw the deceased alive on 10-1-1966 , and that death occurred at 1:20 PM , from causes and on the date stated above.			
22a. SIGNATURE J. A. Pagan, M.D.		22b. DATE SIGNED 10-3-66	
22c. PHYSICIAN'S NAME (Type) J. A. Pagan, M.D.		22d. ADDRESS RIDGELEY, W. VA.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 10-5-66	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR James F. Scarpelli Cumberland, Md.		25a. REC'D BY REGISTRAR DATE OCT 10 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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FOR STATE HEALTH DEPT.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 011			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				d. STREET ADDRESS 535 Fayette Street			
3. NAME OF DECEASED (Type or print) CECIL E BEEMAN				4. DATE OF DEATH 10/10/1966 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/9/1909	
9. AGE (In years lost birthday) 57 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Care taker-Rose Hill Cemetery				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Gilmore, MD.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Andrew Beeman				14. MOTHER'S MAIDEN NAME Mary Green			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT (WIFE) Address Eva Beeman Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION, LEFT Days 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) CORONARY SCLEROSIS -- DUE TO (c) CORONARY THROMBOSIS Days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10-10-66			
				Address (Street, city, town, or county) Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/12/1966		23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Lonaconing, MD.	
24. FUNERAL DIRECTOR GEORGE EICHHORN				ADDRESS Lonaconing, MD.			
25a. REC'D BY REGISTRAR OCT 13 1966				25b. REGISTRAR'S SIGNATURE Charles Judge			

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CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 7 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 95 WRIGHT ST.	
3. NAME OF DECEASED (Type or print) First Middle Last LURLINE OPAL BEEMAN		4. DATE OF DEATH Month Day Year OCTOBER 24 19 66	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-1-1922
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) FROSTBURG, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME RICHARD N. WILSON		14. MOTHER'S MAIDEN NAME SUSANNA ADAMS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-12-3661	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Acute, recent myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) due to thrombosis of right coronary artery (c) due to arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH INSTANTLY	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypothyroidism; Obesity; Diabetes mellitus; varicose veins			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1962 , that (I) (we) last saw the deceased alive on 10/23/66 , and that death occurred at 9:40 AM , from causes on and on the date stated above.			
22a. SIGNATURE Dr. S. G. Weisman		22b. DATE SIGNED 10/25/66	
22c. PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN		22d. ADDRESS 59 GREENE ST.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 27, 1966	
23c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		23d. LOCATION (City or Town) (County) (State) Frostburg, Allegany Md.	
24. FUNERAL DIRECTOR John J. Hafer, Jr.		25a. REC'D BY REGISTRAR John J. Hafer, Jr.	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE OCT 31 1966	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13472

CERTIFICATE OF DEATH

13467

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL				d. STREET ADDRESS 220 GREENE STREET		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
3. NAME OF DECEASED (Type or print) MARY First Middle Last BENDER				4. DATE OF DEATH Month OCT Day 8 Year 1966				
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-25-80		
9. AGE (In years last birthday) 85 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Saleslady		11. BIRTHPLACE (County & State, or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME ROBERT SIZER				14. MOTHER'S MAIDEN NAME FARRELL, Margaret				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-05-8225		17. INFORMANT Miss Phyllis Feaga Address 536 Greene St. Cumberland, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage (Complication) DUE TO (b) Hypertension C.V. Disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from June 1966, to Oct 8, 1966, that (I) (we) last saw the deceased alive on Oct 8, 1966, and that death occurred at 12:30 AM, from causes and on the date stated above.								
22a. SIGNATURE B. M. Schindler				22b. DATE SIGNED 10/9/66		22c. PHYSICIAN'S NAME (Type) B. SCHINDLER M.D.		
22d. ADDRESS 43 GREENE STREET Cumb. Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/11/66		23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.		
24. FUNERAL DIRECTOR H. Wayne George				25a. REC'D BY REGISTRAR DATE OCT 13 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

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VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 13472 Item 9 Film G282 11/7/66 mh CERTIFICATE OF DEATH 13468					
1. PLACE OF DEATH COUNTY ALLEGANY STATE MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 17 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			d. STREET ADDRESS 721 COLUMBIA AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) MRS. ELLENORA N. BOYLAND			4. DATE OF DEATH Month OCT. Day 22 Year 19 66		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/28/84	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND	
13. FATHER'S NAME FLANAGAN, JOSEPH			14. MOTHER'S MAIDEN NAME Catherine Payton		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-48-0417		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage Meningeal Rupt. DUE TO (b) Hypertension - arteriosclerosis DUE TO (c) Senility					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1950 , 19 to 1966 , that (I) (we) last saw the deceased alive on 22 OCT 1966, and that death occurred at 7:53 AM from causes and on the date stated above.					
22a. SIGNATURE Charles B. Whitworth M.D.			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type or print) DR. F. B. WHITWORTH			22d. ADDRESS 305 WASHINGTON ST. CUMBERLAND MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/25/66	23c. NAME OF CEMETERY OR CREMATORY St. Patricks Cem.		23d. LOCATION (City or Town) (County) (State) Cumberland Md.
24. FUNERAL DIRECTOR Louis Stein Inc. Cumb. Md.			25a. REC'D BY REGISTRAR DATE OCT 28 1966		25b. REGISTRAR'S SIGNATURE Charles Judge

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

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13473
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 9 Film G382 11/4/66 mh
13469
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN lb 6 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BITTINGER d. STREET ADDRESS 11-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MRS. SARAH A. BRENNEMAN First Middle Last 4. DATE OF DEATH OCT. 23 19 66 Month Day Year		5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 1/25/92 9. AGE (In years last birthday) yrs. 74 1/5 IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Own Home 11. BIRTHPLACE (County & State, or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOSIAH BITTINGER 14. MOTHER'S MAIDEN NAME KATHERINE ORNDOL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. -- 17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD. Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO (b) Chronic Myocarditis DUE TO (c) Diabetic Hypertension Complicated by Cerebrovascular Disease CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Stenosis of Right Heart Valve INTERVAL BETWEEN ONSET AND DEATH 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 21. I certify that (I) (this hospital) attended the deceased from Oct 16, 1966 , to Oct 23, 1966 , that (I) (we) last saw the deceased alive on Oct 23, 1966 and that death occurred at 10:15 AM , from causes and on the date stated above. 22a. SIGNATURE DR. G.O. HIMMELWRIGHT 22b. DATE SIGNED 10/25/66 22c. PHYSICIAN'S NAME (Type) DR. G.O. HIMMELWRIGHT 22d. ADDRESS 133 VIRGINIA AVE. CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 10/26/66 23c. NAME OF CEMETERY OR CREMATORY Bittinger Cem. 23d. LOCATION (City or Town) (County) (State) Bittinger, Garrett, Md.		24. FUNERAL DIRECTOR Don J Newman Grantsville, Md. ADDRESS 25a. REC'D BY REGISTRAR OCT 31 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH					
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
13474			CERTIFICATE OF DEATH		
13470			13470		
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 21 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			d. STREET ADDRESS 52 ELDER STREET		
3. NAME OF DECEASED (Type or print) First JOHN Middle F. Last BURGESS			4. DATE OF DEATH Month OCTOBER Day 26 Year 19 66		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-16-1897	9. AGE (In years last birthday) yrs. 69	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATCHMAN		10b. KIND OF BUSINESS OR INDUSTRY BROCK SALVAGE CO.		11. BIRTHPLACE (County & State, or foreign country) LAUREL DALE, W.VA.	
13. FATHER'S NAME GEORGE BURGESS			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO. 214-07-1029		
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chloroform Paralytic DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) Cumbersville, Md.					
21. I certify that (I) (this hospital) attended the deceased from 10/25/66 , 19 66 , at that (I) (we) last saw the deceased alive on 10/25/66 , 19 66 , and that death occurred at 12:30 A.M. , from causes and on the date stated above.					
22a. SIGNATURE DR. R. J. WILLIAMS			22b. DATE SIGNED 10/27/66		
22c. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS			22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 28, 1966	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.			25a. REC'D BY REGISTRAR DATE OCT 31 1966		
			25b. REGISTRAR'S SIGNATURE Charles Judge		

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13475

CERTIFICATE OF DEATH

13471

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 7 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sylvan Retreat		d. STREET ADDRESS Barton <i>011</i>	
3. NAME OF DECEASED (Type or print) First Mary Middle Jane Last Clark		4. DATE OF DEATH Month Oct. Day 9 Year 1966	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/28/72
9. AGE (In years last birthday) 94 yrs.		IF UNDER 1 YEAR Months 9 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jefferson Howell		14. MOTHER'S MAIDEN NAME Harriet Moore	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT James Clark - Barton, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic degenerative disease 4221 DUE TO (b) Arteriosclerosis, general & cerebral DUE TO (c) 17:11 - Senile psychosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12/21, 1959 , to Oct 9, 1966 that (I) (we) last saw the deceased alive on Oct. 8, 1966 , and that death occurred at 11P M , from causes and on the date stated above.			
22a. SIGNATURE L. B. Mathews		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) L. B. Mathews, M.D.		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF Oct. 12, 1966	23c. NAME OF CEMETERY OR CREMATORY Lanard Hill	23d. LOCATION (City or Town) (County) (State) Moscow Mills Md.
24. FUNERAL DIRECTOR E. J. Bral Westport, Md.		25a. REC'D BY REGISTRAR OCT 13 1966	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13171

CERTIFICATE OF DEATH

13171

Alfred W.

Married

Male

White

Married

Male

White

Given Name

First

Middle

Last

Married

Married

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CERTIFICATE OF DEATH

13476

13472

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN 1b Years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eckhart d. STREET ADDRESS 01-1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Nellie Middle Grace Last Close			4. DATE OF DEATH Month Oct. 7, Day 19 Year 66				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 28, 1911	9. AGE (In years last birthday) yrs. 54	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coining		10b. KIND OF BUSINESS OR INDUSTRY Celanese		11. BIRTHPLACE (County & State, or foreign country) Maryland			
13. FATHER'S NAME James Close (deceased)			14. MOTHER'S MAIDEN NAME Elizabeth Brode (deceased)				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-07-6491		17. INFORMANT Address Patients chart William J Chabot			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH 6 Mon		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Sept 30 , 19 66 , to Oct 7 , 19 66 , that (I) (we) last saw the deceased alive on Oct 7 , 19 66 , and that death occurred at _____ M, from causes on and on the date stated above.							
22a. SIGNATURE W. Spiggle			22b. DATE SIGNED Oct 10, 1966				
22c. PHYSICIAN'S NAME (Type) Dr. M. Slick & Dr. W. Spiggle			22d. ADDRESS N. Smallwood St., Cumberland, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct 10, 1966	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Gardens	23d. LOCATION (City or Town) (County) (State) Near Cumberland Allegany Md				
24. FUNERAL DIRECTOR John J. Hafer, 230 Balto Ave., Cumberland, Md			25a. REC'D BY REGISTRAR DATE OCT 11 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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OFFICE OF THE

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CERTIFICATE OF DEATH

13477

13473

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN 1b Years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland d. STREET ADDRESS 209 West Second Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Armetha Mae Crawford		4. DATE OF DEATH Month October Day 18 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1921
9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR Months 11 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY West Virginia	
11. BIRTHPLACE (County & State, or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Gilbert E. Haenftling		14. MOTHER'S MAIDEN NAME Emma Appel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. Mrs. Victor Merkle, 470 Goethe St. Cumberland Md	
17. INFORMANT Mrs. Victor Merkle, 470 Goethe St. Cumberland Md		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Cervix CONDITIONS, if any, which gave rise to immediate cause (b) with metastasis (c) with metastasis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at....., 19....., from the causes and on the date stated above.			
22a. SIGNATURE Oliver H. Nadeau, M.D.		22b. DATE SIGNED October 20, 1966	
22c. PHYSICIAN'S NAME (Type) Oliver H. Nadeau, M.D.		22d. ADDRESS 600 Virginia Avenue, Cumberland, Md.	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Burial Oct. 21, 1966		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	
23d. LOCATION (City, town or county) (State) Cumberland, Alleany Co. Md.		25a. REC'D BY REGISTRAR OCT 21 1966	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

13476

CERTIFICATE OF DEATH

13474

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 15 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 456 BALTIMORE AVE.	
3. NAME OF DECEASED (Type or print) First LAURA Middle V. Last CRAWFORD		4. DATE OF DEATH Month OCTOBER Day 5 Year 1966	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-28-1907
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	9. AGE (In years last birthday) 59 yrs.
11. BIRTHPLACE (County & State, or foreign country) PETERSBURG, W. VA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME PHILLIP SWICK		14. MOTHER'S MAIDEN NAME IDA LEWIS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5870 IMMEDIATE CAUSE (a) Acute Pancreatitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Chronic Typhoid			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/20 , 19 66 to 10/5 , 19 66 ; that (I) (we) last saw the deceased alive on 10/5 , 19 66 , and that death occurred at 6:30 PM on the date stated above.			
22a. SIGNATURE Leo H. Key, Jr.		22b. DATE SIGNED 10/9/66	
22c. PHYSICIAN'S NAME (Type) DR. LEO H. LEY		22d. ADDRESS 456 N. CENTRE ST.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 8, 1966	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE OCT 14 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1947

1947

CERTIFICATE OF DEATH

ALLIANCE

HANFORD

ALLIANCE

12 DAYS

CUMBERLAND

MEMORIAL HOSPITAL

450 ELLIOTT AVE.

LABOR

V. CHAMBERLAIN

CHAMBERLAIN

WHITE

3-22-1907

IDA LEWIS

WHITE

MEMORIAL HOSPITAL, CUMBERLAND, MD.

LEO H. HUBB

350 N. CUMBERLAND ST.

OCT 1 1947

Wm. J. Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13479

CERTIFICATE OF DEATH

13475

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 6 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 113 W. ELDER STREET	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle E. Last CRAWFORD		4. DATE OF DEATH Month OCTOBER Day 8 Year 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7-29-1896
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 01 Days 1 Hours 01 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED-Filtration		10b. KIND OF BUSINESS OR INDUSTRY Textile	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND Keyser, W.V.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES HENRY CRAWFORD		14. MOTHER'S MAIDEN NAME ALBERTA L. MICHAELS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. MEMORIAL HOSPITAL - CUMBERLAND, MD.	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory failure 5371 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Pulmonary DUE TO (c) Pulmonary Emphysema + fibrosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Heart Disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12:01 to 10/8 , 19 66 , that (I) (we) last saw the deceased alive on 10/8 , 19 66 , and that death occurred at 12:01 M, from causes and on the date stated above.			
22a. SIGNATURE DR. S. G. WEISMAN		22b. DATE SIGNED 10/11/66	
22c. PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN		22d. ADDRESS 59 GREENE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 10, 1966	
23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR OCT 13 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

13830

13475

CERTIFICATE OF DEATH

ALLIANCE

ALLIANCE

ALLIANCE

CUNNINGHAM

8 DAYS

CUNNINGHAM

113 W. BLOOM STREET

MEMORIAL HOSPITAL

10 OCTOBER 8 20

CHANDLER

VILLIA

WHITE

DECEASED

CHARLES HENRY CRAWFORD

ALBERTA L. MICHAEL

MEMORIAL HOSPITAL - CUNNINGHAM, NO.



DR. GREENE

DR. GREENE

13480

CERTIFICATE OF DEATH

13476

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 01.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS HOMewood ADDITION RT. # 1	
3. NAME OF DECEASED (Type or print) ELMER <i>Washington</i> CROWE		4. DATE OF DEATH Month OCTOBER Day 8 Year 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-6-96
9. AGE (In years last birthday) yrs. 70		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Mining	
11. BIRTHPLACE (County & State, or foreign country) MT. SAVAGE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elmer R. Crowe		14. MOTHER'S MAIDEN NAME XXXXXXXXXX(D) IDA MAE (CROWE) <i>Clarks, Md.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-10-132581	
17. INFORMANT Mrs. Ethel B. Crowe <i>Address Rt. #1 Homewood</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral aneurysm of head DUE TO 156.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from January 1947 to Oct 8, 1966 , that (I) (we) last saw the deceased alive on Oct 8, 1966 and that death occurred at 7 M. from causes and on the date stated above.			
22a. SIGNATURE <i>Dr. B. Schindler</i>		22b. DATE SIGNED 10/9/66	
22c. PHYSICIAN'S NAME (Type) DR. B. SCHINDLER, MD.		22d. ADDRESS 43 GREENE ST. CUMBERLAND, MARYLAND.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 10/11/66	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.
24. FUNERAL DIRECTOR H. Wayne George <i>Cumberland, Md.</i>		25a. REC'D BY REGISTRAR DATE OCT 13 1966	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

25461

PASS

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
13482		MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
13477			
1. PLACE OF DEATH o. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 227 CECELIA STREET	
3. NAME OF DECEASED (Type or print) JONATHAN B. DODD		4. DATE OF DEATH Month OCT. Day 31 Year 19 66	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 25, 1878
9. AGE (In years lost birthday) 87 yrs.		10. IF UNDER 1 YEAR Months 01 Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DELIVERY CLERK		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES DODD		14. MOTHER'S MAIDEN NAME ANNA BOWSER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 705 05 4465	
17. INFORMANT J. WILSON DODD		Address ROUTE 3, BEDFORD, PA.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4221 IMMEDIATE CAUSE (a) Chronic Myocarditis DUE TO (b) Arteriosclerotic Cardiovascular disease DUE TO (c) Fracture of Right Hip			INTERVAL BETWEEN ONSET AND DEATH Months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture of Right Hip			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at Home	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 10:00 a.m. Oct. 2 19 66		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work Home	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Cumberland, Alleg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelis		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 10/31/66		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF NOV. 2, 1966	
23c. NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL PARK		23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.	
24. FUNERAL DIRECTOR BYRON KIGHT		25a. REC'D BY REGISTRAR DATE NOV 7 1966	
ADDRESS CUMBERLAND, MD.		25b. REGISTRAR'S SIGNATURE Charles Judge	

5526

100

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13482

CERTIFICATE OF DEATH

13478

1. PLACE OF DEATH o. COUNTY <u>Allegheny</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Hyndman</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyndman</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital</u>			d. STREET ADDRESS <u>Rt. #1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Christopher Emerick</u>			4. DATE OF DEATH Month Day Year <u>10/25/66</u> 19 <u>66</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/15/79</u>		9. AGE (In years last birthday) <u>87</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Valentine Emerick</u>			14. MOTHER'S MAIDEN NAME <u>Katherine Smith Emerick</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>195--30-4070</u>	17. INFORMANT Address <u>Chart-information given by wife</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure, due arteriosclerosis</u> DUE TO 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Diabetic Acidosis, recurrent, severe</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>24 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Early uremia due circulatory failure. Old strokes.</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>10-20-66</u> , 19 <u>66</u> , to <u>10-25-66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10-25-66</u> , 19 <u>66</u> , and that death occurred <u>11:25</u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>Wyand F. Doerner, Jr.</u>		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>10-27-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wyand F. Doerner, Jr., M.D.</u>		22d. ADDRESS <u>414 N. Mechanic St., Cumberland, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct. 29, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Comps Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hyndman, Somerset, Co., Pa.</u>	
24. FUNERAL DIRECTOR <u>Harvey H. Zeigler</u>		ADDRESS <u>Hyndman, Pa.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 2 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13437

13437

13437

Diabetic ketoacidosis, recurrent, severe
Diabetic ketoacidosis, recurrent, severe

Diabetic ketoacidosis, recurrent, severe

10-25-66

10-25-66

10-25-66

11:30

10-27-66

10

Diabetic ketoacidosis, recurrent, severe

13483

CERTIFICATE OF DEATH

13479

1. PLACE OF DEATH o. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. LENGTH OF STAY IN 1b 17 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		01-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kyle Nursing Home				d. STREET ADDRESS 31 Grant St., Cresaptown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frederick		First Alvey		Lost Gates		4. DATE OF DEATH Month 10 Day 22 Year 66	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/12/1884	
9. AGE (In years lost birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) Paw Paw, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telegraph Opr.		10b. KIND OF BUSINESS OR INDUSTRY B & O Railroad		13. FATHER'S NAME Daniel W. Gates		14. MOTHER'S MAIDEN NAME Elizabeth Thomas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO. 705-05-8200		17. INFORMANT Frederick A. Gates, Jr. Address Cumberland, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Advanced Arteriosclerosis Acute cystitis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June , 19 65 to Oct 21 , 19 66 , that (II) (we) last saw the deceased alive on Oct 21 , 19 66 , and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE L.R. Miles		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10.24.66			
22c. PHYSICIAN'S NAME (Type) L.R. MILES, JR., M.D.		22d. ADDRESS LONA CONING MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/25/66		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md.	
24. FUNERAL DIRECTOR Philip B. Wendt				ADDRESS Cumberland, Maryland		25a. REC'D BY REGISTRAR OCT 31 1966	
				25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13473

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13484

CERTIFICATE OF DEATH

13480

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		e. STREET ADDRESS 120 N. Smallwood St.	
3. NAME OF DECEASED (Type or print) First Hildegard Middle Glick Last Glick		4. DATE OF DEATH Month Oct. Day 4 Year 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 26, 1895
9. AGE (In years last birthday) yrs. 71		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Michael Weisel (deceased)		14. MOTHER'S MAIDEN NAME Margaret Long (deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Patients chart		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uncontrolled hyperemia 5701 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) small Venous mesenteric thrombosis bowel DUE TO (c) Paralytic ileus and gastric dilatation		INTERVAL BETWEEN ONSET AND DEATH 3 days 3 day 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cholelithiasis 9/28/66		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/29 , 19 66 , to 10/4 , 19 66 , that (I) (we) lost saw the deceased alive on 10/6 , 19 66 , and that death occurred at 9:30 PM , from causes and on the date stated above.			
22a. SIGNATURE Thomas F. Lewis		22b. DATE SIGNED 10/6/66	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 7, 1966	
23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md	
24. FUNERAL DIRECTOR Louis Stein, Inc.		25a. REC'D BY REGISTRAR OCT 10 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13481

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rawlings				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rawlings			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route #3				d. STREET ADDRESS Route #3			
3. NAME OF DECEASED (Type or print) First Middle Last Philip S. Gordon				4. DATE OF DEATH Month Day Year Oct 15, 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1, 1901	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RT. Carman		10b. KIND OF BUSINESS OR INDUSTRY B & O RR		11. BIRTHPLACE (County & State, or foreign country) Oldtown, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ulysses Gordon				14. MOTHER'S MAIDEN NAME Margaret Crabtree			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. ✓			
17. INFORMANT Norma L. Gordon				Address Rawlings, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Comp. infarcting atherosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH oh 1953	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1953 to Oct 15, 1966 , that (I) (we) last saw the deceased alive on Oct 14, 1966 , and that death occurred at 9:45 A.M. from the causes and on the date stated above.							
22a. SIGNATURE T. C. Giffin, M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) T. C. Giffin, M.D.				22d. ADDRESS Keyser, West Va.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 18, 1966		23c. NAME OF CEMETERY OR CREMATORY Waxler Cemetery		23d. LOCATION (City, town or county) (State) Rawlings, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Allen M. Rotruck				ADDRESS Keyser, West Va.		25a. REC'D BY REGISTRAR DATE OCT 19 1966	
				25b. REGISTRAR'S SIGNATURE J. Charles Judge			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Maryland

Alimony

Rowling

Rowling

Route 13

Route 13

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April 1, 1907

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Kayser, West Va.

Rowling, Md.

Rowling, Md.

Rowling, Md.

Kayser, West Va.

13486

CERTIFICATE OF DEATH

13482

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE W. VA. b. COUNTY HAMPSHIRE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 85-3	
3. NAME OF DECEASED (Type or print) First Middle Last CHERYL HAINES		4. DATE OF DEATH Month Day Year OCT. 4 19 66	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/28/66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) yrs. 3
11. BIRTHPLACE (County & State, or foreign country) ROMNEY, W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS HAINES		14. MOTHER'S MAIDEN NAME MYRTLE CORBIN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> 7735 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>immaturity</u> DUE TO (c) <u>30 wks gestation</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10-2</u> , 19 <u>66</u> , to <u>10-4</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>10-4</u> 19 <u>66</u> and that death occurred at <u>9:30 AM</u> from causes and on the date stated above.			
22a. SIGNATURE <i>Robert J. Dawson M.D.</i>		22b. DATE SIGNED <u>10-5-66</u>	
22c. PHYSICIAN'S NAME (Type) DR. ROBERT DAWSON		22d. ADDRESS 500 GREENE ST. CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 5/66	23c. NAME OF CEMETERY OR CREMATORY Mt Dale Cemetery	23d. LOCATION (City or Town) (County) (State) Shanks, Hampshire, W. Va.
24. FUNERAL DIRECTOR Wade H. McKee		25a. REC'D BY REGISTRAR Augusta, West Va.	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE OCT 21 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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GENERAL HOSPITAL

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GENERAL HOSPITAL, CHURCHLAND, W. VA.

GENERAL HOSPITAL, CHURCHLAND, W. VA.

GENERAL HOSPITAL, CHURCHLAND, W. VA.

13487

CERTIFICATE OF DEATH

13488

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 42 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLDTOWN		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL					d. STREET ADDRESS 01-1		
3. NAME OF DECEASED (Type or print) First BLUIE Middle M. Last HAUGH				4. DATE OF DEATH Month OCTOBER Day 19 Year 1966			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-26-1880		9. AGE (In years last birthday) yrs. 86	10. IF UNDER 1 YEAR Months 01 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) OLDTOWN, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN H. RICKENBURG				14. MOTHER'S MAIDEN NAME ELIZABETH BARTH			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the colon DUE TO (b) 6 mos Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Cardiovascular disease							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/19/66 to 10/25/66 , that (I) (we) last saw the deceased alive on 10/19/66 , and that death occurred at 9:25 PM M, from causes and on the date stated above.							
22a. SIGNATURE Dr. S. G. Weisman				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/20/66	
22c. PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN				22d. ADDRESS 59 GREENE ST.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT. 22, 1966		23c. NAME OF CEMETERY OR CREMATORY OLDTOWN CEMETERY		23d. LOCATION (City or Town) (County) (State) OLDTOWN, MD.	
24. FUNERAL DIRECTOR BYRON KIGHT				ADDRESS CUMBERLAND, MD.		25a. REC'D BY REGISTRAR DATE OCT 25 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

3231

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13488					13484				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY ALLEGANY MARYLAND					a. STATE MARYLAND b. COUNTY ALLEGANY				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SLABTOWN					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SLABTOWN				
c. LENGTH OF STAY IN 1b 22 YEARS					d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last CARL WILLIAM HELMICK					Month Day Year OCTOBER 15, 1966				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 21, 1907		9. AGE (in years last birthday) 59 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRE-TREATING ROOM		10b. KIND OF BUSINESS OR INDUSTRY TEXTILE MFG.		11. BIRTHPLACE (County & State, or foreign country) PARSONS, WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME CHESTER ARTHUR HELMICK					14. MOTHER'S MAIDEN NAME SARAH JANE BLACKBURN				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES					16. SOCIAL SECURITY NO. 3-16-279-28-27		17. INFORMANT RF Ad 889, MT. SAVAGE, MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4344 Coronary occlusion					hr.				
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Chronic Cardiac disease					years.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Sept , 19 66 , to Oct 15 , 19 66 , that (I) (we) last saw the deceased alive on Oct-10 , 19 66 , and that death occurred at M , from the causes and on the date stated above.									
22a. SIGNATURE John B. Davis					22b. DATE SIGNED 10/17/66		22c. PHYSICIAN'S NAME (Type) JOHN B. DAVIS, M.D.		
22d. ADDRESS 2 BROADWAY, FROSTBURG, MD.					22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF OCT. 19, 1966		23c. NAME OF CEMETERY OR CREMATORY MT. SAVAGE CEMETERY		23d. LOCATION (City, town or county) (State) MT. SAVAGE, MD.		
24. FUNERAL DIRECTOR MARILOU M. SOWERS					25a. REC'D BY REGISTRAR OCT 20 1966				
25b. REGISTRAR'S SIGNATURE Charles Judge									

13484

13484

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13489

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13485

1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cresaptown, Maryland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D. O. A. Memorial Hospital</u>			d. STREET ADDRESS <u>Along Winchester Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Theodore Raymond Hershberger</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>15</u> Year <u>1966</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 27, 1885</u>	9. AGE (In years lost birthday) yrs. <u>80</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired, Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Corp. Celanese Fibres</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Abraham Hershberger</u>			14. MOTHER'S MAIDEN NAME <u>Susan Shook</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-07-1907</u>		17. INFORMANT <u>Mrs. Leonard Stouffer, Cresaptown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY SCLEROSIS</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> -----
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D. EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>October 15, 1966</u> Address (Street, city, town, or county) <u>Cumberland, Md</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/18/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>	23d. LOCATION (City or Town)	(County)	(State)
24. FUNERAL DIRECTOR <u>H. Wayne George, Cumberland, Md.</u>			25a. REC'D BY REGISTRAR DATE <u>OCT 20 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

13182

13182

13480

CERTIFICATE OF DEATH

13486

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 47 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MR. JACOB J. HESS		4. DATE OF DEATH Month OCTOBER Day 22 Year 66	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/1/01
9. AGE (In years last birthday) 65		10. IF UNDER 1 YEAR Months 01 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MINER		10b. KIND OF BUSINESS OR INDUSTRY COAL MINES	
11. BIRTHPLACE (County & State, or foreign country) ECKHART, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH HESS		14. MOTHER'S MAIDEN NAME REGINA MC CUSKEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-01-3788	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal Carcinoma DUE TO (b) Cancer Ca Abdomen DUE TO (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) Cum. Alleg. Md.	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/22/66 , 19 66 , to 10/1 , 19 66 , that (I) (we) last saw the deceased alive on 11.50 AM , and that death occurred at 11.50 AM , from causes and on the date stated above.			
22a. SIGNATURE DR. R.J. WILLIAMS		22b. DATE SIGNED 10/24/66	
22c. PHYSICIAN'S NAME (Type) DR. R.J. WILLIAMS		22d. ADDRESS 122 S. CENTRE ST. CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10-25-1966	23c. NAME OF CEMETERY OR CREMATORY FROSTBURG, MEMORIAL	23d. LOCATION (City or Town) (County) (State) FROSTBURG MD
24. FUNERAL DIRECTOR Joseph R. Auerst, Frostburg, Md		25a. REC'D BY REGISTRAR DATE OCT 26 1966	25b. REGISTRAR'S SIGNATURE John H. Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13492

13487

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland, Md.</u>			
c. LENGTH OF STAY In 1b <u>Life</u>				d. STREET ADDRESS <u>509 Linden Street</u>			
e. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>509 Linden Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Francis</u> Middle <u>P.</u> Last <u>Hodel</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>23</u> Year <u>1966</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 28, 1890</u>		9. AGE (In years last birthday) <u>76</u> yrs.		10. FINDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Messenger</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B & O RR.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Cumberland Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Hodel</u>				14. MOTHER'S MAIDEN NAME <u>Barbara McMahon</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. V. M. McHally</u>		Address <u>Cumb. Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC LYMPHATIC LEUKEMIA</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-10</u> , 19 <u>66</u> to <u>10-23</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10-21</u> , 19 <u>66</u> , and that death occurred at <u>6:30</u> P.M., from the causes and on the date stated above.							
22a. SIGNATURE <u>L. Michael Glick</u>				22b. DATE SIGNED <u>10-24-66</u>		22c. PHYSICIAN'S NAME (Type) <u>L. MICHAEL GLICK</u>	
22d. ADDRESS <u>126 W. SMALLWOOD</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/26/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Peter & Paul</u>		23d. LOCATION (City, town or county) (State) <u>Cumberland Md</u>	
24. FUNERAL DIRECTOR <u>Louis Stein Inc.</u>				25a. REC'D BY REGISTRAR <u>Charles J. J...</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	
ADDRESS <u>Cumb. Md</u>				DATE <u>OCT 28 1966</u>			

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13488

CERTIFICATE OF DEATH

13488

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		d. STREET ADDRESS 23 Virginia Avenue	
3. NAME OF DECEASED (Type or print) First Boyd Middle W. Last Hosier		4. DATE OF DEATH Month 10 Day 6 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/27/93
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 10 Days 6 IF UNDER 24 HRS. Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) B & O (retired)		10b. KIND OF BUSINESS OR INDUSTRY Engineer RR	
11. BIRTHPLACE (County & State, or foreign country) Martinsburg, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME P. Marshall Hosier		14. MOTHER'S MAIDEN NAME Martha Willard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 705-07-8726	
17. INFORMANT patient's chart		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 1 yr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emphysema, chronic bronchitis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-2- , 19 65 , to 10-6- , 19 66 , that (I) (we) last saw the deceased alive on 10-6- , 19 66 , and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE L. Brings		22b. DATE SIGNED 10-7-66	
22c. PHYSICIAN'S NAME (Type) Dr. Lewis Brings, M.D.		22d. ADDRESS 57 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 9, 1966	
23c. NAME OF CEMETERY OR CREMATORY Queens Point Cemetery		23d. LOCATION (City or Town) (County) (State) Keyser, W. Va.	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE OCT 14 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

8348

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other person is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
13489											
1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lonaconing c. LENGTH OF STAY IN lb MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kyle Nurseing Home						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Poolesville, MD. d. STREET ADDRESS 15-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) WALTER First B. Middle N. Last HOSKINSON						4. DATE OF DEATH Month 10/15/1966 Day 19 Year 19					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH -----1887		9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY Maryland				11. BIRTHPLACE (State or foreign country) USA			
13. FATHER'S NAME Thomas Hoskinson						14. MOTHER'S MAIDEN NAME Gertrude Fletchall					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. Estella Hoskinson, Poolsville, MD.				17. INFORMANT Address (SISTER)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Coronary Sclerosis DUE TO (c) Sudden											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE Benedict Skitarelic EXAMINER'S NAME (Type) Benedict Skitarelic				DATE SIGNED 10/15/1966							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10/18/1966		22c. NAME OF CEMETERY OR CREMATORY Monocacy Cemetery		22d. LOCATION (City, town, or country) (State) Beallsville, MD.			
23. FUNERAL DIRECTOR W.C.Hilton ADDRESS Barnesville, Maryland.						24a. REC'D BY REGISTRAR DATE OCT 21 1966					
						24b. REGISTRAR'S SIGNATURE Charles Judge					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. If you please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

13494

CERTIFICATE OF DEATH

13490

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG,		c. LENGTH OF STAY IN lb 20 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		d. STREET ADDRESS 68 W. MAIN STREET	
3. NAME OF DECEASED (Type or print) First GEORGE Middle G. Last JEFFRIES		4. DATE OF DEATH Month OCTOBER Day 18th Year 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 11th, 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. CUSTODIAN		10b. KIND OF BUSINESS OR INDUSTRY ELKS LODGE	9. AGE (In years last birthday) 87 yrs.
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SAMUEL JEFFRIES		14. MOTHER'S MAIDEN NAME SUSAN HOCKING	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 213-12-9031	17. INFORMANT MRS. EDITH JEFFRIES, Address 68 W. MAIN ST., FROSTBURG, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334 X ACUTE BRAIN SYNDROME DUE TO (b) CEREBRAL ARTERIOSCLEROSIS DUE TO (c) 1 month Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from SEPT. 28, 1966 to OCT. 18, 1966 , that (I) (we) last saw the deceased alive on OCT. 18, 1966 , and that death occurred at 8:25 P.M. from causes and on the date stated above.			
22a. SIGNATURE G. Paige Strong		22b. DATE SIGNED OCT. 19, 1966	
22c. PHYSICIAN'S NAME (Type) A. PAIGE STRONG,		22d. ADDRESS 167 E. MAIN ST - FROSTBURG, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10-20-66	23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEMORIAL PARK	23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR.		25a. REC'D BY REGISTRAR DATE OCT 21 1966	
ADDRESS FROSTBURG, MD.		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

13480

CENTRAL DE DEUT

13480

1. Name of the person or entity		2. Address	
3. Telephone number		4. Date of birth	
5. Date of death		6. Date of entry	
7. Date of exit		8. Date of return	
9. Date of departure		10. Date of arrival	
11. Date of departure		12. Date of arrival	
13. Date of departure		14. Date of arrival	
15. Date of departure		16. Date of arrival	
17. Date of departure		18. Date of arrival	
19. Date of departure		20. Date of arrival	
21. Date of departure		22. Date of arrival	
23. Date of departure		24. Date of arrival	
25. Date of departure		26. Date of arrival	
27. Date of departure		28. Date of arrival	
29. Date of departure		30. Date of arrival	
31. Date of departure		32. Date of arrival	
33. Date of departure		34. Date of arrival	
35. Date of departure		36. Date of arrival	
37. Date of departure		38. Date of arrival	
39. Date of departure		40. Date of arrival	
41. Date of departure		42. Date of arrival	
43. Date of departure		44. Date of arrival	
45. Date of departure		46. Date of arrival	
47. Date of departure		48. Date of arrival	
49. Date of departure		50. Date of arrival	
51. Date of departure		52. Date of arrival	
53. Date of departure		54. Date of arrival	
55. Date of departure		56. Date of arrival	
57. Date of departure		58. Date of arrival	
59. Date of departure		60. Date of arrival	
61. Date of departure		62. Date of arrival	
63. Date of departure		64. Date of arrival	
65. Date of departure		66. Date of arrival	
67. Date of departure		68. Date of arrival	
69. Date of departure		70. Date of arrival	
71. Date of departure		72. Date of arrival	
73. Date of departure		74. Date of arrival	
75. Date of departure		76. Date of arrival	
77. Date of departure		78. Date of arrival	
79. Date of departure		80. Date of arrival	
81. Date of departure		82. Date of arrival	
83. Date of departure		84. Date of arrival	
85. Date of departure		86. Date of arrival	
87. Date of departure		88. Date of arrival	
89. Date of departure		90. Date of arrival	
91. Date of departure		92. Date of arrival	
93. Date of departure		94. Date of arrival	
95. Date of departure		96. Date of arrival	
97. Date of departure		98. Date of arrival	
99. Date of departure		100. Date of arrival	

13495

CERTIFICATE OF DEATH

13491

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG	
c. LENGTH OF STAY IN lb LIFE		d. STREET ADDRESS 40 GRANT STREET	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last EIMER A. JONES		4. DATE OF DEATH Month Day Year OCTOBER 29, 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 19, 1902
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY HERCULES POWDER	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ENOCH JONES		14. MOTHER'S MAIDEN NAME JANE ARTHUR	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 274-07-7473	
17. INFORMANT MRS. MARGARET JONES, FROSTBURG, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X DUE TO Jaemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) chronic nephritis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10-28- , 1966, to 10-29- , 1966, that (I) (we) last saw the deceased alive on 10-29- , 1966, and that death occurred at 4:20 PM , from causes and on the date stated above.			
22a. SIGNATURE G. Paige Strong		22b. DATE SIGNED 10/30/66	
22c. PHYSICIAN'S NAME (Type) A. PAIGE STRONG		22d. ADDRESS FROSTBURG, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF NOV. 1, 1966	23c. NAME OF CEMETERY OR CREMATORY FB'G. MEMORIAL PARK	23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.		25a. REC'D BY REGISTRAR DATE NOV 3 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

1851

4221

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH					
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
13498			13494		
CERTIFICATE OF DEATH			13494		
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			d. STREET ADDRESS 135 ARCH STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) MARY First E Middle KALBAUGH Last			4. DATE OF DEATH Month 10 Day 15 Year 1966		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-30-1888		9. AGE (In years last birthday) yrs. 77-77
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) MARYLAND - CUMBERLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Ebenezer ALLEN			14. MOTHER'S MAIDEN NAME CATHERINE OSS		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD. Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Acute Stroke with left hemiplegia, cerebral edema and coma DUE TO (c) Arteriosclerotic CVD					INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from October 10, 1966 , to Oct. 15, 1966 , that (I) (we) last saw the deceased alive on Oct. 15, 1966 , and that death occurred at 5:40 PM , from causes and on the date stated above.					
22a. SIGNATURE DR. W F DOERNER, Jr., M.D.			22b. DATE SIGNED 10-17-66		22c. PHYSICIAN'S NAME (Type) DR. W F DOERNER, Jr., M.D.
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 18, 1966	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.			25a. REC'D BY REGISTRAR DATE OCT 19 1966		
			25b. REGISTRAR'S SIGNATURE Charles Judge		

222

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1. *Chlorophyll a* (Chl *a*)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13496

CERTIFICATE OF DEATH

13492

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
c. LENGTH OF STAY IN lb 6 HRS. 15 MIN.		d. STREET ADDRESS 108 SPRINGDALE ST.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last NELLIE M KAMMAUF		4. DATE OF DEATH Month Day Year OCT. 30 19 66	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-29-92
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME THOMAS SMITH		14. MOTHER'S MAIDEN NAME LYDIA GREEN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 DUE TO Myocardial Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Cumby Allegany Md	
21. I certify that (I) (this hospital) attended the deceased from 10/29/66 , 19__, to 10/30/66 , 19__, that (I) (we) last saw the deceased alive on 10/30/66 , 19__, and that death occurred at 5 P M, from causes and on the date stated above.			
22a. SIGNATURE R.J. WILLIAMS		22b. DATE SIGNED 10/31/66	
22c. PHYSICIAN'S NAME (Type) R.J. WILLIAMS		22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 2, 1966	
23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. - Allegany	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR NOV 3 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

13488

STATE OF DEATH

13488

ALLEGANY

MARYLAND

ALLEGANY

CUMBERLAND

8 HRS.
15 MIN.

CUMBERLAND

MEMORIAL HOSPITAL

101 SPRINGDALE ST.

X

GB

30

OCT.

KAMMARE

WELTIE

M

10-23-23

RENAULT WHITE

X

74

CUMBERLAND, MD.

W.D.

LYDIA GREEN

THOMAS SMITH

MEMORIAL HOSPITAL, CUMBERLAND, MD.

101 SPRINGDALE ST., CUMBERLAND, MD.

101 SPRINGDALE ST.

CERTIFICATE OF DEATH

13497

13493

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital				d. STREET ADDRESS 625 Shriver Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anthony Middle P. Last Kastner				4. DATE OF DEATH Month 10 Day 11 Year 19 66			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/12/84	
				9. AGE (In years lost birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Fireman				10b. KIND OF BUSINESS OR INDUSTRY Brewery Worker		11. BIRTHPLACE (County & State, or foreign country) Maryland, Allegany Co.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Antone Kastner				14. MOTHER'S MAIDEN NAME Mary Gross			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 214-05-4774-4		17. INFORMANT patient's chart			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Congestive Ht. Failure DUE TO (b) Myocardial Degeneration DUE TO (c) Crownary Artery Disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/10 , 19 66 , to 10/11 , 19 66 , that (I) (we) lost saw the deceased alive on 10/11 , 19 66 , and that death occurred at 6 P M, from causes on and on the date stated above.							
22a. SIGNATURE Leo H. Ley Jr				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/13/66	
22c. PHYSICIAN'S NAME (Type) Leo H. Ley Jr. M.D.				22d. ADDRESS 456 N. Centre St.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/14/66		23c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul		23d. LOCATION (City or Town) (County) (State) Cumberland MD	
24. FUNERAL DIRECTOR Louis Stein Inc. Cumb. MD.				25a. REC'D BY REGISTRAR DATE OCT 17 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13108

CERTIFICATE OF DEATH

13108

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES	
JAMES H. HARRIS		45		M		W		1910		New York		Heart Disease		Natural		J. H. Harris		J. H. Harris	
BORN		1865																	
DIED		1910																	
PLACE OF BIRTH		New York																	
OCCUPATION		Teacher																	
EDUCATION		High School																	
MARRIED		Yes																	
SPOUSE		Mary H. Harris																	
CHILDREN		3																	
FATHER		John H. Harris																	
MOTHER		Sarah H. Harris																	
BROTHERS		2																	
SISTERS		1																	
RELIGION		Protestant																	
CHURCH		St. Paul's																	
MINISTER		Rev. J. H. Harris																	
PRESTIGE		None																	
EVALUATION		None																	
FAMILY HISTORY		None																	
MEDICAL HISTORY		None																	
PHYSICAL EXAMINATION		None																	
LABORATORY EXAMINATION		None																	
POST-MORTEM EXAMINATION		None																	
HISTORICAL RECORD		None																	
GENERAL RECORD		None																	
SPECIAL RECORD		None																	
REMARKS		None																	
SIGNATURE OF REGISTRAR		J. H. Harris																	
SIGNATURE OF WITNESSES		J. H. Harris																	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE DEATH RECORD ACT OF 1910.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Allegany					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lonaconing					c. LENGTH OF STAY IN 1b 3 years						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kyle NursingHome					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Lucinda Middle Kinser Last Kinser					4. DATE OF DEATH Month October Day 29 Year 1966						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 20, 1896		9. AGE (In years last birthday) 70			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Corriganville, Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Henry Nickle					14. MOTHER'S MAIDEN NAME unkn						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 217-14-4292		17. INFORMANT Mr. Dklen Geiger, Corriganville, Md.			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Ischemia 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic CV Diseases DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									INTERVAL BETWEEN ONSET AND DEATH years years		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 1962 to Oct 29, 1966 , that (I) (we) last saw the deceased alive on Oct 27, 1966 , and that death occurred at PM , from the causes and on the date stated above.										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
22a. SIGNATURE LR MILES JR					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-31-66				
22c. PHYSICIAN'S NAME (Type) LR MILES JR					22d. ADDRESS LONA CONING MD						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Nov. 1, 1966		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION (City, town or county) (State) Cumberland, Maryland				
24. FUNERAL DIRECTOR Howard H. Feigler					ADDRESS Hyndman, Pennsylvania		25a. REC'D BY REGISTRAR NOV 4 1966		25b. REGISTRAR'S SIGNATURE J Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
13500		CERTIFICATE OF DEATH	
13496			
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN lb 4 WEEKS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		e. STREET ADDRESS 40 WASHINGTON ST.	
3. NAME OF DECEASED (Type or print) First ALBERT Middle J. Last LAEMMERT		4. DATE OF DEATH Month OCT. Day 15TH Year 19 66	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 22nd, 1880
9. AGE (In years lost birthday) 86 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. JANITOR	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HENRY LAEMMERT		14. MOTHER'S MAIDEN NAME KATHERINE BRODE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 215-10-4466A	
17. INFORMANT Mrs. CLARA LAEMMERT,		Address 40 WASHINGTON ST., FROSTBURG, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO Cerebral occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis - advanced (c) years -		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept , 19 66 to Oct 15 , 19 66 that (I) (we) last saw the deceased alive on Sept 15 , 19 66 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE John B. Davis M.D.		22b. DATE SIGNED 10/17/66	
22c. PHYSICIAN'S NAME (Type) JOHN B. DAVIS,		22d. ADDRESS 2 BROADWAY, FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10-18-66	23c. NAME OF CEMETERY OR CREMATORY F'BG. MEMORIAL PARK	23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR.		25a. REC'D BY REGISTRAR DATE OCT 19 1966	
ADDRESS FROSTBURG, MD.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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13500

GENERAL INFORMATION		SPECIFIC INFORMATION	
NAME	ADDRESS	DATE	TIME
ALFRED W. BROWN	1234 MAIN ST, NEW YORK, NY	10/15/50	10:30 AM
JOHN D. SMITH	5678 PARK AVE, NEW YORK, NY	10/16/50	11:00 AM
MARY E. JONES	9010 BROADWAY, NEW YORK, NY	10/17/50	12:00 PM
CHARLES F. WHITE	2345 EIGHTH AVE, NEW YORK, NY	10/18/50	1:00 PM
ELIZABETH K. GREEN	6789 FIFTH AVE, NEW YORK, NY	10/19/50	2:00 PM
WILLIAM H. BLACK	10110 SEVENTH AVE, NEW YORK, NY	10/20/50	3:00 PM
ROBERT L. GRAY	4567 THIRD AVE, NEW YORK, NY	10/21/50	4:00 PM
HENRY J. MILLER	8901 SECOND AVE, NEW YORK, NY	10/22/50	5:00 PM
ANNE M. WATSON	3456 FIRST AVE, NEW YORK, NY	10/23/50	6:00 PM
THOMAS R. HARRIS	7890 NINTH AVE, NEW YORK, NY	10/24/50	7:00 PM
JOSEPH A. CLARK	2109 TENTH AVE, NEW YORK, NY	10/25/50	8:00 PM
SARAH B. LEWIS	5432 ELEVENTH AVE, NEW YORK, NY	10/26/50	9:00 PM
EDWARD G. ROSS	9876 TWELFTH AVE, NEW YORK, NY	10/27/50	10:00 PM
MICHAEL P. KING	1357 THIRTEENTH AVE, NEW YORK, NY	10/28/50	11:00 PM
LUCAS N. BAKER	4680 FOURTEENTH AVE, NEW YORK, NY	10/29/50	12:00 AM
OLIVIA S. NELSON	7913 FIFTEENTH AVE, NEW YORK, NY	10/30/50	1:00 AM
FRANK T. HENDERSON	1246 SIXTEENTH AVE, NEW YORK, NY	10/31/50	2:00 AM
HELEN W. COOPER	5789 SEVENTEENTH AVE, NEW YORK, NY	11/01/50	3:00 AM
GEORGE V. REED	9012 EIGHTEENTH AVE, NEW YORK, NY	11/02/50	4:00 AM
IDA F. BARNES	2345 NINETEENTH AVE, NEW YORK, NY	11/03/50	5:00 AM
WALTER D. FOSTER	6789 TWENTY AVE, NEW YORK, NY	11/04/50	6:00 AM
JOAN K. PETERSON	10110 TWENTY ONE AVE, NEW YORK, NY	11/05/50	7:00 AM
ALBERT J. MORGAN	4567 TWENTY TWO AVE, NEW YORK, NY	11/06/50	8:00 AM
BETTY L. HILL	8901 TWENTY THREE AVE, NEW YORK, NY	11/07/50	9:00 AM
JOHN R. WALKER	3456 TWENTY FOUR AVE, NEW YORK, NY	11/08/50	10:00 AM
MARGARET A. STEVENSON	7890 TWENTY FIVE AVE, NEW YORK, NY	11/09/50	11:00 AM
CHARLES E. TOLSON	2109 TWENTY SIX AVE, NEW YORK, NY	11/10/50	12:00 PM
JOHN F. CONRAD	5432 TWENTY SEVEN AVE, NEW YORK, NY	11/11/50	1:00 PM
ELIZABETH C. WATSON	9876 TWENTY EIGHT AVE, NEW YORK, NY	11/12/50	2:00 PM
THOMAS H. REED	1357 TWENTY NINE AVE, NEW YORK, NY	11/13/50	3:00 PM
JOSEPH M. BAKER	4680 THIRTY AVE, NEW YORK, NY	11/14/50	4:00 PM
SARAH J. NELSON	7913 THIRTY ONE AVE, NEW YORK, NY	11/15/50	5:00 PM
FRANK L. HENDERSON	1246 THIRTY TWO AVE, NEW YORK, NY	11/16/50	6:00 PM
HELEN M. COOPER	5789 THIRTY THREE AVE, NEW YORK, NY	11/17/50	7:00 PM
GEORGE W. REED	9012 THIRTY FOUR AVE, NEW YORK, NY	11/18/50	8:00 PM
IDA E. BARNES	2345 THIRTY FIVE AVE, NEW YORK, NY	11/19/50	9:00 PM
WALTER F. FOSTER	6789 THIRTY SIX AVE, NEW YORK, NY	11/20/50	10:00 PM
JOAN H. PETERSON	10110 THIRTY SEVEN AVE, NEW YORK, NY	11/21/50	11:00 PM
ALBERT K. MORGAN	4567 THIRTY EIGHT AVE, NEW YORK, NY	11/22/50	12:00 AM
BETTY J. HILL	8901 THIRTY NINE AVE, NEW YORK, NY	11/23/50	1:00 AM
JOHN L. WALKER	3456 FORTY AVE, NEW YORK, NY	11/24/50	2:00 AM
MARGARET P. STEVENSON	7890 FORTY ONE AVE, NEW YORK, NY	11/25/50	3:00 AM
CHARLES F. TOLSON	2109 FORTY TWO AVE, NEW YORK, NY	11/26/50	4:00 AM
JOHN G. CONRAD	5432 FORTY THREE AVE, NEW YORK, NY	11/27/50	5:00 AM
ELIZABETH H. WATSON	9876 FORTY FOUR AVE, NEW YORK, NY	11/28/50	6:00 AM
THOMAS J. REED	1357 FORTY FIVE AVE, NEW YORK, NY	11/29/50	7:00 AM
JOSEPH R. BAKER	4680 FORTY SIX AVE, NEW YORK, NY	11/30/50	8:00 AM
SARAH K. NELSON	7913 FORTY SEVEN AVE, NEW YORK, NY	12/01/50	9:00 AM
FRANK H. HENDERSON	1246 FORTY EIGHT AVE, NEW YORK, NY	12/02/50	10:00 AM
HELEN J. COOPER	5789 FORTY NINE AVE, NEW YORK, NY	12/03/50	11:00 AM
GEORGE L. REED	9012 FIFTY AVE, NEW YORK, NY	12/04/50	12:00 PM
IDA M. BARNES	2345 FIFTY ONE AVE, NEW YORK, NY	12/05/50	1:00 PM
WALTER N. FOSTER	6789 FIFTY TWO AVE, NEW YORK, NY	12/06/50	2:00 PM
JOAN O. PETERSON	10110 FIFTY THREE AVE, NEW YORK, NY	12/07/50	3:00 PM
ALBERT P. MORGAN	4567 FIFTY FOUR AVE, NEW YORK, NY	12/08/50	4:00 PM
BETTY Q. HILL	8901 FIFTY FIVE AVE, NEW YORK, NY	12/09/50	5:00 PM
JOHN R. WALKER	3456 FIFTY SIX AVE, NEW YORK, NY	12/10/50	6:00 PM
MARGARET S. STEVENSON	7890 FIFTY SEVEN AVE, NEW YORK, NY	12/11/50	7:00 PM
CHARLES T. TOLSON	2109 FIFTY EIGHT AVE, NEW YORK, NY	12/12/50	8:00 PM
JOHN U. CONRAD	5432 FIFTY NINE AVE, NEW YORK, NY	12/13/50	9:00 PM
ELIZABETH V. WATSON	9876 SIXTY AVE, NEW YORK, NY	12/14/50	10:00 PM
THOMAS W. REED	1357 SIXTY ONE AVE, NEW YORK, NY	12/15/50	11:00 PM
JOSEPH X. BAKER	4680 SIXTY TWO AVE, NEW YORK, NY	12/16/50	12:00 AM
SARAH Y. NELSON	7913 SIXTY THREE AVE, NEW YORK, NY	12/17/50	1:00 AM
FRANK Z. HENDERSON	1246 SIXTY FOUR AVE, NEW YORK, NY	12/18/50	2:00 AM
HELEN AA. COOPER	5789 SIXTY FIVE AVE, NEW YORK, NY	12/19/50	3:00 AM
GEORGE BB. REED	9012 SIXTY SIX AVE, NEW YORK, NY	12/20/50	4:00 AM
IDA CC. BARNES	2345 SIXTY SEVEN AVE, NEW YORK, NY	12/21/50	5:00 AM
WALTER DD. FOSTER	6789 SIXTY EIGHT AVE, NEW YORK, NY	12/22/50	6:00 AM
JOAN EE. PETERSON	10110 SIXTY NINE AVE, NEW YORK, NY	12/23/50	7:00 AM
ALBERT FF. MORGAN	4567 SEVENTY AVE, NEW YORK, NY	12/24/50	8:00 AM
BETTY GG. HILL	8901 SEVENTY ONE AVE, NEW YORK, NY	12/25/50	9:00 AM
JOHN HH. WALKER	3456 SEVENTY TWO AVE, NEW YORK, NY	12/26/50	10:00 AM
MARGARET II. STEVENSON	7890 SEVENTY THREE AVE, NEW YORK, NY	12/27/50	11:00 AM
CHARLES JJ. TOLSON	2109 SEVENTY FOUR AVE, NEW YORK, NY	12/28/50	12:00 PM
JOHN KK. CONRAD	5432 SEVENTY FIVE AVE, NEW YORK, NY	12/29/50	1:00 PM
ELIZABETH LL. WATSON	9876 SEVENTY SIX AVE, NEW YORK, NY	12/30/50	2:00 PM
THOMAS MM. REED	1357 SEVENTY SEVEN AVE, NEW YORK, NY	12/31/50	3:00 PM
JOSEPH NN. BAKER	4680 SEVENTY EIGHT AVE, NEW YORK, NY	01/01/51	4:00 PM
SARAH OO. NELSON	7913 SEVENTY NINE AVE, NEW YORK, NY	01/02/51	5:00 PM
FRANK PP. HENDERSON	1246 EIGHTY AVE, NEW YORK, NY	01/03/51	6:00 PM
HELEN QQ. COOPER	5789 EIGHTY ONE AVE, NEW YORK, NY	01/04/51	7:00 PM
GEORGE RR. REED	9012 EIGHTY TWO AVE, NEW YORK, NY	01/05/51	8:00 PM
IDA SS. BARNES	2345 EIGHTY THREE AVE, NEW YORK, NY	01/06/51	9:00 PM
WALTER TT. FOSTER	6789 EIGHTY FOUR AVE, NEW YORK, NY	01/07/51	10:00 PM
JOAN UU. PETERSON	10110 EIGHTY FIVE AVE, NEW YORK, NY	01/08/51	11:00 PM
ALBERT VV. MORGAN	4567 EIGHTY SIX AVE, NEW YORK, NY	01/09/51	12:00 AM
BETTY WW. HILL	8901 EIGHTY SEVEN AVE, NEW YORK, NY	01/10/51	1:00 AM
JOHN XX. WALKER	3456 EIGHTY EIGHT AVE, NEW YORK, NY	01/11/51	2:00 AM
MARGARET YY. STEVENSON	7890 EIGHTY NINE AVE, NEW YORK, NY	01/12/51	3:00 AM
CHARLES ZZ. TOLSON	2109 NINETY AVE, NEW YORK, NY	01/13/51	4:00 AM
JOHN AAA. CONRAD	5432 NINETY ONE AVE, NEW YORK, NY	01/14/51	5:00 AM
ELIZABETH BBB. WATSON	9876 NINETY TWO AVE, NEW YORK, NY	01/15/51	6:00 AM
THOMAS CCC. REED	1357 NINETY THREE AVE, NEW YORK, NY	01/16/51	7:00 AM
JOSEPH DDD. BAKER	4680 NINETY FOUR AVE, NEW YORK, NY	01/17/51	8:00 AM
SARAH EEE. NELSON	7913 NINETY FIVE AVE, NEW YORK, NY	01/18/51	9:00 AM
FRANK FFF. HENDERSON	1246 NINETY SIX AVE, NEW YORK, NY	01/19/51	10:00 AM
HELEN GGG. COOPER	5789 NINETY SEVEN AVE, NEW YORK, NY	01/20/51	11:00 AM
GEORGE HHH. REED	9012 NINETY EIGHT AVE, NEW YORK, NY	01/21/51	12:00 PM
IDA III. BARNES	2345 HUNDRED AVE, NEW YORK, NY	01/22/51	1:00 PM
WALTER LLL. FOSTER	6789 HUNDRED ONE AVE, NEW YORK, NY	01/23/51	2:00 PM
JOAN MLL. PETERSON	10110 HUNDRED TWO AVE, NEW YORK, NY	01/24/51	3:00 PM
ALBERT NLL. MORGAN	4567 HUNDRED THREE AVE, NEW YORK, NY	01/25/51	4:00 PM
BETTY OLL. HILL	8901 HUNDRED FOUR AVE, NEW YORK, NY	01/26/51	5:00 PM
JOHN PLL. WALKER	3456 HUNDRED FIVE AVE, NEW YORK, NY	01/27/51	6:00 PM
MARGARET QLL. STEVENSON	7890 HUNDRED SIX AVE, NEW YORK, NY	01/28/51	7:00 PM
CHARLES RLL. TOLSON	2109 HUNDRED SEVEN AVE, NEW YORK, NY	01/29/51	8:00 PM
JOHN SLL. CONRAD	5432 HUNDRED EIGHT AVE, NEW YORK, NY	01/30/51	9:00 PM
ELIZABETH TLL. WATSON	9876 HUNDRED NINE AVE, NEW YORK, NY	01/31/51	10:00 PM
THOMAS ULL. REED	1357 HUNDRED TEN AVE, NEW YORK, NY	02/01/51	11:00 PM
JOSEPH VLL. BAKER	4680 HUNDRED ELEVEN AVE, NEW YORK, NY	02/02/51	12:00 AM
SARAH WLL. NELSON	7913 HUNDRED TWELVE AVE, NEW YORK, NY	02/03/51	1:00 AM
FRANK XLL. HENDERSON	1246 HUNDRED THIRTEEN AVE, NEW YORK, NY	02/04/51	2:00 AM
HELEN YLL. COOPER	5789 HUNDRED FOURTEEN AVE, NEW YORK, NY	02/05/51	3:00 AM
GEORGE ZLL. REED	9012 HUNDRED FIFTEEN AVE, NEW YORK, NY	02/06/51	4:00 AM
IDA AALL. BARNES	2345 HUNDRED SIXTEEN AVE, NEW YORK, NY	02/07/51	5:00 AM
WALTER BLL. FOSTER	6789 HUNDRED SEVENTEEN AVE, NEW YORK, NY	02/08/51	6:00 AM
JOAN CLL. PETERSON	10110 HUNDRED EIGHTEEN AVE, NEW YORK, NY	02/09/51	7:00 AM
ALBERT DLL. MORGAN	4567 HUNDRED NINETEEN AVE, NEW YORK, NY	02/10/51	8:00 AM
BETTY ELL. HILL	8901 HUNDRED TWENTY AVE, NEW YORK, NY	02/11/51	9:00 AM
JOHN FLL. WALKER	3456 HUNDRED TWENTY ONE AVE, NEW YORK, NY	02/12/51	10:00 AM
MARGARET GLL. STEVENSON	7890 HUNDRED TWENTY TWO AVE, NEW YORK, NY	02/13/51	11:00 AM
CHARLES HLL. TOLSON	2109 HUNDRED TWENTY THREE AVE, NEW YORK, NY	02/14/51	12:00 PM
JOHN ILL. CONRAD	5432 HUNDRED TWENTY FOUR AVE, NEW YORK, NY	02/15/51	1:00 PM
ELIZABETH JLL. WATSON	9876 HUNDRED TWENTY FIVE AVE, NEW YORK, NY	02/16/51	2:00 PM
THOMAS KLL. REED	1357 HUNDRED TWENTY SIX AVE, NEW YORK, NY	02/17/51	3:00 PM
JOSEPH LLL. BAKER	4680 HUNDRED TWENTY SEVEN AVE, NEW YORK, NY	02/18/51	4:00 PM
SARAH MLL. NELSON	7913 HUNDRED TWENTY EIGHT AVE, NEW YORK, NY	02/19/51	5:00 PM
FRANK NLL. HENDERSON	1246 HUNDRED TWENTY NINE AVE, NEW YORK, NY	02/20/51	6:00 PM
HELEN OLL. COOPER	5789 HUNDRED THIRTY AVE, NEW YORK, NY	02/21/51	7:00 PM
GEORGE PLL. REED	9012 HUNDRED THIRTY ONE AVE, NEW YORK, NY	02/22/51	8:00 PM
IDA QLL. BARNES	2345 HUNDRED THIRTY TWO AVE, NEW YORK, NY	02/23/51	9:00 PM
WALTER RLL. FOSTER	6789 HUNDRED THIRTY THREE AVE, NEW YORK, NY	02/24/51	10:00 PM
JOAN SLL. PETERSON	10110 HUNDRED THIRTY FOUR AVE, NEW YORK, NY	02/25/51	11:00 PM
ALBERT TLL. MORGAN	4567 HUNDRED THIRTY FIVE AVE, NEW YORK, NY	02/26/51	12:00 AM
BETTY ULL. HILL	8901 HUNDRED THIRTY SIX AVE, NEW YORK, NY	02/27/51	1:00 AM
JOHN VLL. WALKER	3456 HUNDRED THIRTY SEVEN AVE, NEW YORK, NY	02/28/51	2:00 AM
MARGARET WLL. STEVENSON	7890 HUNDRED THIRTY EIGHT AVE, NEW YORK, NY	02/29/51	3:00 AM
CHARLES XLL. TOLSON	2109 HUNDRED THIRTY NINE AVE, NEW YORK, NY	03/01/51	4:00 AM
JOHN YLL. CONRAD	5432 HUNDRED FORTY AVE, NEW YORK, NY	03/02/51	5:00 AM
ELIZABETH ZLL. WATSON	9876 HUNDRED FORTY ONE AVE, NEW YORK, NY	03/03/51	6:00 AM
THOMAS AALL. REED	1357 HUNDRED FORTY TWO AVE, NEW YORK, NY	03/04/51	7:00 AM
JOSEPH BLL. BAKER	4680 HUNDRED FORTY THREE AVE, NEW YORK, NY	03/05/51	8:00 AM
SARAH CLL. NELSON	7913 HUNDRED FORTY FOUR AVE, NEW YORK, NY	03/06/51	9:00 AM
FRANK DLL. HENDERSON	1246 HUNDRED FORTY FIVE AVE, NEW YORK, NY	03/07/51	10:00 AM
HELEN ELL. COOPER	5789 HUNDRED FORTY SIX AVE, NEW YORK, NY	03/08/51	11:00 AM
GEORGE FLL. REED	9012 HUNDRED FORTY SEVEN AVE, NEW YORK, NY	03/09/51	12:00 PM
IDA GLL. BARNES	2345 HUNDRED FORTY EIGHT AVE, NEW YORK, NY	03/10/51	1:00 PM
WALTER HLL. FOSTER	6789 HUNDRED FORTY NINE AVE, NEW YORK, NY	03/11/51	2:00 PM
JOAN ILL. PETERSON	10110 HUNDRED FIFTY AVE, NEW YORK, NY	03/12/51	3:00 PM
ALBERT JLL. MORGAN	4567 HUNDRED FIFTY ONE AVE, NEW YORK, NY	03/13/51	4:00 PM
BETTY KLL. HILL	8901 HUNDRED FIFTY TWO AVE, NEW YORK, NY	03/14/51	5:00 PM
JOHN LLL. WALKER	3456 HUNDRED FIFTY THREE AVE, NEW YORK, NY	03/15/51	6:00 PM
MARGARET MLL. STEVENSON	7890 HUNDRED FIFTY FOUR AVE, NEW YORK, NY	03/16/51	7:00 PM
CHARLES NLL. TOLSON	2109 HUNDRED FIFTY FIVE AVE, NEW YORK, NY	03/17/51	8:00 PM
JOHN OLL. CONRAD	5432 HUNDRED FIFTY SIX AVE, NEW YORK, NY	03/18/51	9:00 PM
ELIZABETH PLL. WATSON	9876 HUNDRED FIFTY SEVEN AVE, NEW YORK, NY	03/19/51	10:00 PM
THOMAS QLL. REED	1357 HUNDRED FIFTY EIGHT AVE, NEW YORK, NY	03/20/51	11:00 PM
JOSEPH RLL. BAKER	4680 HUNDRED FIFTY NINE AVE, NEW YORK, NY	03/21/51	12:00 AM
SARAH SLL. NELSON	7913 HUNDRED SIXTY AVE, NEW YORK, NY	03/22/51	1:00 AM
FRANK TLL. HENDERSON	1246 HUNDRED SIXTY ONE AVE, NEW YORK, NY	03/23/51	2:00 AM
HELEN ULL. COOPER	5789 HUNDRED SIXTY TWO AVE, NEW YORK, NY	03/24/51	3:00 AM
GEORGE VLL. REED	9012 HUNDRED SIXTY THREE AVE, NEW YORK, NY	03/25/51	4:00 AM
IDA WLL. BARNES	2345 HUNDRED SIXTY FOUR AVE, NEW YORK, NY	03/26/51	5:00 AM
WALTER XLL. FOSTER	6789 HUNDRED SIXTY FIVE AVE, NEW YORK, NY	03/27/51	6:00 AM
JOAN YLL. PETERSON	10110 HUNDRED SIXTY SIX AVE, NEW YORK, NY	03/28/51	7:00 AM
ALBERT ZLL. MORGAN	4567 HUNDRED SIXTY SEVEN AVE, NEW YORK, NY	03/29/51	8:00 AM
BETTY AALL. HILL	8901 HUNDRED SIXTY EIGHT AVE, NEW YORK, NY	03/30/51	9:00 AM
JOHN BLL. WALKER	3456 HUNDRED SIXTY NINE AVE, NEW YORK, NY	03/31/51	10:00 AM
MARGARET CLL. STEVENSON	7890 HUNDRED SEVENTY AVE, NEW YORK, NY	04/01/51	11:00 PM
CHARLES DLL. TOLSON	2109 HUNDRED SEVENTY ONE AVE, NEW YORK, NY	04/02/51	12:00 AM
JOHN ELL. CONRAD	5432 HUNDRED SEVENTY TWO AVE, NEW YORK, NY	04/03/51	1:00 AM
ELIZABETH FLL. WATSON	9876 HUNDRED SEVENTY THREE AVE, NEW YORK, NY	04/04/51	2:00 AM
THOMAS GLL. REED	1357 HUNDRED SEVENTY FOUR AVE, NEW YORK, NY	04/05/51	3:00 AM
JOSEPH HLL. BAKER	4680 HUNDRED SEVENTY FIVE AVE, NEW YORK, NY	04/06/51	4:00 AM
SARAH ILL. NELSON	7913 HUNDRED SEVENTY SIX AVE, NEW YORK, NY	04/07/51	5:00 AM
FRANK JLL. HENDERSON	1246 HUNDRED SEVENTY SEVEN AVE, NEW YORK, NY	04/08/51	6:00 AM
HELEN KLL. COOPER	5789 HUNDRED SEVENTY EIGHT AVE, NEW YORK, NY	04/09/51	7:00 AM
GEORGE LLL. REED	9012 HUNDRED SEVENTY NINE AVE, NEW YORK, NY	04/10/51	8:00 AM
IDA MLL. BARNES	2345 HUNDRED EIGHTY AVE, NEW YORK, NY	04/11/51	9:00 AM
WALTER NLL. FOSTER	6789 HUNDRED EIGHTY ONE AVE, NEW YORK, NY	04/12/51	10:00 AM
JOAN OLL. PETERSON	10110 HUNDRED EIGHTY TWO AVE, NEW YORK, NY	04/13/51	11:00 PM
ALBERT PLL. MORGAN	4567 HUNDRED EIGHTY THREE AVE, NEW YORK, NY	04/14/51	12:00 AM
BETTY QLL. HILL	8901 HUNDRED EIGHTY FOUR AVE, NEW YORK, NY	04/15/51	1:00 AM
JOHN RLL. WALKER	3456 HUNDRED EIGHTY FIVE AVE, NEW YORK, NY	04/16/51	2:00 AM
MARGARET SLL. STEVENSON	7890 HUNDRED EIGHTY SIX AVE, NEW YORK, NY	04/17/51	3:00 AM
CHARLES TLL. TOLSON	2109 HUNDRED EIGHTY SEVEN AVE, NEW YORK, NY	04/18/51	4:00 AM
JOHN ULL. CONRAD	5432 HUNDRED EIGHTY EIGHT AVE, NEW YORK, NY	04/19/51	5:00 AM
ELIZABETH VLL. WATSON	9876 HUNDRED EIGHTY NINE AVE, NEW YORK, NY	04/20/51	6:00 AM
THOMAS WLL. REED	1357 HUNDRED NINETY AVE, NEW YORK, NY	04/21/51	7:00 AM
JOSEPH XLL. BAKER	4680 HUNDRED NINETY ONE AVE, NEW YORK, NY	04/22/51	8:00 AM
SARAH YLL. NELSON	7913 HUNDRED NINETY TWO AVE, NEW YORK, NY	04/23/51	9:00 AM
FRANK ZLL. HENDERSON	1246 HUNDRED NINETY THREE AVE, NEW YORK, NY	04/24/51	10:00 AM
HELEN AALL. COOPER	5789 HUNDRED NINETY FOUR AVE, NEW YORK, NY	04/25/51	11:00 PM
GEORGE BLL. REED	9012 HUNDRED NINETY FIVE AVE, NEW YORK, NY	04/26/51	12:00 AM
IDA CLL. BARNES	2345 HUNDRED NINETY SIX AVE, NEW YORK, NY	04/27/51	1:00 AM
WALTER DLL. FOSTER	6789 HUNDRED NINETY SEVEN AVE, NEW YORK, NY	04/28/51	2:00 AM
JOAN ELL. PETERSON	10110 HUNDRED NINETY EIGHT AVE, NEW YORK, NY	04/29/51	3:00 AM
ALBERT FLL. MORGAN	4567 HUNDRED NINETEEN AVE, NEW YORK, NY	04/30/51	4:00 AM
BETTY GLL. HILL	8901 HUNDRED TWENTY AVE, NEW YORK, NY	05/01/51	5:00 AM
JOHN HLL. WALKER	3456 HUNDRED		

13502

CERTIFICATE OF DEATH

13497

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 2 wks.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 16 POTOMAC STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DAISY		First		Middle S.		Last LIPSCOMB		4. DATE OF DEATH OCTOBER		Month		Day 5		Year 1966	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-12-89		9. AGE (In years lost birthdays) 76		IF UNDER 1 YEAR Months		Doys		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) AURORA, W. VA.				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME ISSAAC WORTING						14. MOTHER'S MAIDEN NAME OLIVE (HARDESTY)									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. 217-48-3755		17. INFORMANT PT'S CHART						Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) senile dementia DUE TO (b) uremia DUE TO (c) arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 260X												INTERVAL BETWEEN ONSET AND DEATH 1 week			
												PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Sept 27 , 19 66 , to Oct 5 , 19 66 that (I) (we) last saw the deceased alive on Oct 5 , 19 66 and that death occurred at 10 M, from causes and on the date stated above.															
22a. SIGNATURE [Signature]						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-6-66					
22c. PHYSICIAN'S NAME (Type) DR. B. SCHINDLER, M.D.						22d. ADDRESS 43 GREENE ST CUMBERLAND, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/8/66		23c. NAME OF CEMETERY OR CREMATORY Aurora Cemetery		23d. LOCATION (City or Town) (County) (State) Aurora W. Va.									
24. FUNERAL DIRECTOR Sheld N. Minnich						ADDRESS Oakland, Maryland		25a. REC'D BY REGISTRAR OCT 13 1966		25b. REGISTRAR'S SIGNATURE [Signature]					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13111

13111

13111



13111



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13502

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13498

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u> <u>11-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hosp.</u>				d. STREET ADDRESS <u>508 Marshall St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Conrad</u> Last <u>Loeber</u>				4. DATE OF DEATH Month <u>October</u> Day <u>5</u> Year <u>19 66</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/5/87</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>19</u>		IF UNDER 24 HRS. Hours <u>66</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cumb. Health Dept.</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Conrad Loeber</u>				14. MOTHER'S MAIDEN NAME <u>Emma Judy</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes,</u> <u>W. W. # 1</u>		16. SOCIAL SECURITY NO. <u>214-05-6263</u>		17. INFORMANT <u>Mrs. Wanda L. Shrout</u> Address <u>508 Marshall St. Cumb. Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Contusions of brain</u> DUE TO <u>904.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Skull fracture</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell at daughters home</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>2:00</u> p.m. <u>Sept. 30,</u> <u>66</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Cumberland, Allegany, Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>Cumberland, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/7/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Cumberland, Allegany, Md.</u>	
24. FUNERAL DIRECTOR <u>H. Wayne George</u> <u>Cumberland, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 13 1966</u>			
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

01

02

03

04

05

06

07

08

09

10

13157

13263

Handwritten signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
13502					13499					
1					M					
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital					d. STREET ADDRESS Douglas Ave,			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First M. Lost LOVE					4. DATE OF DEATH Month 10/7/1966 Day 19 Year 19					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/7/1880		9. AGE (In years last birthday) yrs. 86		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Watchiero, Iowa			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Michael Muir					14. MOTHER'S MAIDEN NAME Hannah Jones					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Alice Love, Frederick, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Ischemia 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Coronary Ischemia + insufficiency (c) Advanced Arteriosclerosis					INTERVAL BETWEEN ONSET AND DEATH 6 mos. years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Undiagnosed GI bleeding					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Sept 9 , 1966, to Oct 7 , 1966, that (I) (we) lost saw the deceased alive on Oct 7 , 1966, and that death occurred at 11 P.M. , from causes and on the date stated above.										
22a. SIGNATURE L.R. Miles Jr.					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 10.8.66		
22c. PHYSICIAN'S NAME (Type) L.R. MILES, JR., M.D.					22d. ADDRESS LONA CONING, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/7/1966		23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Lonaconing, MD.			
24. FUNERAL DIRECTOR GEORGE EICHHORN					ADDRESS Lonaconing, MD.		25a. REC'D BY REGISTRAR DATE OCT 11 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

13438

DATE OF DEATH

12503

Allegany

Allegany

Allegany

Longmont

Longmont

Longmont

Longmont

10/1/1966

10/1/1966

10/1/1966

10/1/1966

10/1/1966

10/1/1966

10/1/1966

10/1/1966

10/1/1966

Western, Iowa

Western, Iowa

Western, Iowa

Western, Iowa

Western, Iowa, Frederick, J.
(number in box)

Western, Iowa

Western, Iowa

10/1/1966

10/1/1966

10/1/1966

10/1/1966

10/1/1966

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
5M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 13504 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13500 </div>																							
1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN 1b <u>50 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital D. O. A.</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland LaVale Md.</u> d. STREET ADDRESS <u>Macy Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																		
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Hall</u> Last <u>Macy</u>			4. DATE OF DEATH Month <u>October</u> Day <u>11</u> Year <u>1966</u>		5. SEX <u>Male</u>			6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>													
8. DATE OF BIRTH <u>Nov. 8, 1895</u>			9. AGE (In years last birthday) <u>70</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>			IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		Hours		Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Agent</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>			11. BIRTHPLACE (State or foreign country) <u>New York State</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.																						
Months	Days																						
	Hours																						
	Min.																						
13. FATHER'S NAME <u>Henry H. Macy</u>					14. MOTHER'S MAIDEN NAME <u>Emilie de la Montaigne</u>																		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>W W I</u>			16. SOCIAL SECURITY NO.			17. INFORMANT <u>Emilie Macy LaVale</u>			Address														
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Coronary Occlusion</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <table border="1"> <tr> <td>DUE TO</td> <td>(b)</td> <td>DUE TO</td> <td>(c)</td> </tr> <tr> <td></td> <td><u>Coronary Sclerosis</u></td> <td></td> <td></td> </tr> </table>										DUE TO	(b)	DUE TO	(c)		<u>Coronary Sclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>					
DUE TO	(b)	DUE TO	(c)																				
	<u>Coronary Sclerosis</u>																						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)												
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE <u>Benedict Skitzrelic</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED														
EXAMINER'S NAME (Type) <u>Benedict Skitzrelic, M.D.</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>October 11, 1966</u>														
Address (Street, city, town, or county) <u>Cumberland, Md.</u>																							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>10/14/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Mem. Cem.</u>			23d. LOCATION (City, town or county) <u>Frostburg</u> (State) <u>Md.</u>															
24. FUNERAL DIRECTOR <u>Louis Stein Inc. Cumb. Md.</u>						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>														
ADDRESS						DATE <u>OCT 17 1966</u>																	

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John A. ...

23/04/01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13505

CERTIFICATE OF DEATH

13501

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 12 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS RT.#1, BOX 121	
3. NAME OF DECEASED (Type or print) First ERNEST Middle MARTIN Last MARTIN		4. DATE OF DEATH Month OCTOBER Day 25 Year 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH DEC. 22, 1888
9. AGE (In years and birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 13 Days 15 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) Section		10b. KIND OF BUSINESS OR OCCUPATION Cemetery	
11. BIRTHPLACE (County & State, or foreign country) WESTERNPORT, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT MARTIN		14. MOTHER'S MAIDEN NAME EMMA WRIGHT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 215-10-8015	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic shock DUE TO (b) Bleeding gastric ulcer DUE TO (c) Anterior perforating ulcer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4201			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary artery disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 13 , 19 66 , to Oct 25 , 19 66 ; that (I) (we) last saw the deceased alive on Oct 24 , 19 66 , and that death occurred 8:30 A.M. from causes and on the date stated above.			
22a. SIGNATURE Donald B. Grove		22b. DATE SIGNED 10-26-66	
22c. PHYSICIAN'S NAME (Type) DONALD B. GROVE DR. XXXXXXXXXX		22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/28/66	
23c. NAME OF CEMETERY OR CREMATORY Philos		23d. LOCATION (City or Town) (County) (State) Westernport Md.	
24. FUNERAL DIRECTOR W. J. Bral		25a. REC'D BY REGISTRAR DATE OCT 31 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

13501

STATE OF OHIO

13501

ALLIANCE

PORTLAND

ALLIANCE

WESTPORT

12 DAY

CHARTLAND

W. J. BOX 131

MEMORIAL HOSPITAL

OCTOBER 22

1931

CHIEF

DEC. 22, 1930

WHITE

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WESTPORT, OH.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VR A15ME
SM 1/62

Items 18-24 Film 382 10-24-66 ams Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13506 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13502											
1. PLACE OF DEATH a. COUNTY Allegheny MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegheny					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN lb 3 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grant St. Frostburg				d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Frances L Martin						4. DATE OF DEATH Month Day Year Oct. 8 1966					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-9-1917		9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hwf.				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? United States		
13. FATHER'S NAME Harry Preston						14. MOTHER'S MAIDEN NAME Edith Preston Rose Martin					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 214-07-6312		17. INFORMANT Mr. John V. Martin Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 871.0 Cardiac-Pulmonary Failure DUE TO Barbiturate Poisoning Conditions, if any, which gave rise to immediate cause (b) 2 Hours (c) 2 Hours PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1B.) Deceased accidentally took large amounts of Tuinal							
20c. TIME OF INJURY Month, Day, Year Hour p.m. 5:00 Oct. 8 1966				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> et work et work		20e. PLACE OF INJURY (Home, farm, lecture, street, office bldg., etc.) Home		20f. (City or town) Frostburg		(County) Allegany (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Benedict Skitarelic						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL						22b. DATE THEREOF OCT. 11, 1966		22c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEM? PARK		22d. LOCATION (City, town, or country) Frostburg, MARYLAND	
23. FUNERAL DIRECTOR Lowell M. Sowers, Jr. Hafer Funeral Home, 60 W. Main, Frostburg.						24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Charles Judge			

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1930

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January 1, 1931

February 1, 1931

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April 1, 1931

May 1, 1931

June 1, 1931

July 1, 1931

August 1, 1931

September 1, 1931

October 1, 1931

November 1, 1931

December 1, 1931

January 1, 1932

February 1, 1932

March 1, 1932

13503

CERTIFICATE OF DEATH

13503

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY in 1b 3 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 126 SEYMOUR ST.	
3. NAME OF DECEASED (Type or print) First BERNARD Middle L. Last MATTINGLY		4. DATE OF DEATH Month OCTOBER Day 29 Year 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-19-1890
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Equipment Operator-Construction		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND-CRESAPTOWN	
11. BIRTHPLACE (County & State, or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME BERNARD A. MATTINGLY		14. MOTHER'S MAIDEN NAME ELIZABETH RUHL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-05-8546	
17. INFORMANT MEMORIAL HOSPITAL CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 164 x IMMEDIATE CAUSE (a) Mediastinal carcinoma - cancer DUE TO (b) Obstruction - primary site DUE TO (c) undeferment		INTERVAL BETWEEN ONSET AND DEATH Weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 10/26/66		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/29/66 saw the deceased alive on 10/29/66 , and that death occurred at 1:15 P.M. from causes and on the date stated above.		22a. SIGNATURE DR. S. G. WEISMAN	
22c. PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 10/31/66		23b. DATE THEREOF Oct. 31, 1966	
23c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. - Allegany	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR NOV 4 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13203

13203

CERTIFICATE OF DEATH

ALLEGAN

WARRAND

DAVID

WARRAND

121 SEWARD ST

WARRAND

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WARRAND

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13203

WARRAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 13504 CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Allegany</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u> c. LENGTH OF STAY IN lb <u>60</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Miners Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u> d. STREET ADDRESS <u>29 Frost Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Pearl</u> Middle <u>Hafer</u> Last <u>Mattingly</u>					4. DATE OF DEATH Month <u>9</u> Day <u>9</u> Year <u>1966</u>						
5. SEX <u>Female</u>					6. COLOR OR RACE <u>White</u>						
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>Jan. 9, 1895</u>						
9. AGE (In years last birthday) <u>71</u> yrs.					10. IF UNDER 1 YEAR Months <u>71</u> Days <u>71</u> Hours <u>71</u> Min. <u>71</u>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Funeral Director</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Owned business</u>						
11. BIRTHPLACE (County & State, or foreign country) <u>Cumberland, Maryland</u>					12. CITIZEN OF WHAT COUNTRY <u>United State</u>						
13. FATHER'S NAME <u>Jacob Hafer</u>					14. MOTHER'S MAIDEN NAME <u>Annie Trescher Hafer</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>					16. SOCIAL SECURITY NO. <u>217-01-1398</u>						
17. INFORMANT <u>Mariou M. Sowers Frostburg, Md.</u>					Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MASSIVE CEREBRAL HEMORRHAGE</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>HYPERTENSIVE CVD (ARTERIO-SCLEROTIC)</u> DUE TO (c) <u>3 yrs?</u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>NONE</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>										20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)										20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/9, 1966</u> to <u>10/9, 1966</u> , that (I) (we) last saw the deceased alive on <u>10/9, 1966</u> , and that death occurred at <u>8:30 p.m.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Martin M. Rothstein</u>										22b. DATE SIGNED <u>10/10/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Martin M. Rothstein</u>										22d. ADDRESS <u>Broadway, Frostburg, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>										23b. DATE THEREOF <u>Oct. 12, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Mem. Park</u>										23d. LOCATION (City, town or county) (State) <u>Frostburg, Maryland</u>	
24. FUNERAL DIRECTOR <u>Lowell M. Sowers, Jr.</u>										25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>										DATE <u>OCT 13 1966</u>	

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20261

FOR STATE
HEALTH DEPT.

13509

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13505

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>Rt. # 2 Flintstone</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hosp.</u>				d. STREET ADDRESS <u>Along U. S. Rt. # 40</u>			
3. NAME OF DECEASED (Type or print) First <u>Nina</u> Middle <u>--</u> Last <u>May</u>				4. DATE OF DEATH Month <u>October</u> Day <u>17</u> Year <u>19 66</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 28, 1891</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Ownr home</u>		11. BIRTHPLACE (State or foreign country) <u>Petersburg, W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Benjamin Teeter</u>				14. MOTHER'S MAIDEN NAME <u>Jane Dolly</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Harvey W. May</u> Address <u>717 Princeton St. Cumb. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>4201</u> DUE TO <u>CORONARY SCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>HOURS</u> <u>=====</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <u>Cumberland, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/19/66</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glendale Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Flintstone, Allegany Maryland</u>	
23. FUNERAL DIRECTOR <u>H. Wayne George</u> <u>Cumberland, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 20 1966</u>			
				24b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>			

VR A15ME
5M 1/62

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2 and 3 to the Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Democrat (St. Louis)

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13510

13506

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 6 DAYS			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS 306 HARRISON ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MICHAEL Middle DEWEY Last McKENZIE				4. DATE OF DEATH Month OCTOBER Day 5 Year 19 66			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 29, 1902	
9. AGE (in years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAB DRIVER				10b. KIND OF BUSINESS OR INDUSTRY ASTOR CAB CO.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME GEORGE McKENZIE				14. MOTHER'S MAIDEN NAME DORA McKENZIE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. 215-26-6848		17. INFORMANT 121 W. PRIST ST., RONALD E. McKENZIE, CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Contusions of Brain; Subdural Hem. 9035 DUE TO (b) Skull Fracture Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 6 days 6 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell on sidewalk			
20c. TIME OF INJURY Month, Day, Year Hour 2:30 a.m. Sept. 29, 66 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Cumberland, Alleg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> October 5, 1966	
				Address (Street, city, town, or county) R.D. 9, CUMBERLAND MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT. 8 '66		23c. NAME OF CEMETERY OR CREMATORY ST. MICHAEL'S CEMETERY		23d. LOCATION (City, town or county) (State) FROSTBURG, MD.	
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.				25a. REC'D BY REGISTRAR OCT 10 1966			
				25b. REGISTRAR'S SIGNATURE Charles Judge			

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Contours of brain; Subdural hem. 6 days
Skull exposure 6 days

Comp. 20 48 50 52 54 56 58 60 62 64 66 68 70 72 74 76 78 80 82 84 86 88 90 92 94 96 98 100

October 5, 1960

FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13511

13568

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS 701 White Avenue	
3. NAME OF DECEASED (Type or print) First Arthur Middle Vernon Last Meeks		4. DATE OF DEATH Month 10 Day 23 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/16/1914
9. AGE (In years lost birthday) yrs. 51		IF UNDER 1 YEAR Months 11 Days 7 Hours 19 Min. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY B & O Railroad	
11. BIRTHPLACE (State or foreign country) Delaware W. Carlton, Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arthur Gilbert Meeks		14. MOTHER'S MAIDEN NAME Ethel Esther Hicks	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes 1940's		16. SOCIAL SECURITY NO.	
17. INFORMANT Marcella Gwendolyn Meeks		Address 701 White Ave, Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion Hours 4201 DUE TO (b) Coronary Thrombosis Hours Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Coronary Atherosclerosis ---			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED October 23, 1966		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) Cumberland, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/27/66	23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery	23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md.
24. BURIAL DIRECTOR Philip B. Wendt		25a. REC'D BY REGISTRAR OCT 26 1966	
ADDRESS Cumberland, Md.		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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XX October 23, 1955
Cincinnati, Ohio

RECEIVED OCT 24 1955

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13512

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 8 7 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural BARTON,
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 01-1	
3. NAME OF DECEASED (Type or print) First STANLEY Middle C. Last MOORE		4. DATE OF DEATH Month OCTOBER Day 31 Year 19 66	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-29-1884
9. AGE (In years birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Elec.		10b. KIND OF BUSINESS OR INDUSTRY Ship yard	11. BIRTHPLACE (County & State, or foreign country) BARTON, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME GEORGE MOORE	
14. MOTHER'S MAIDEN NAME Alphema CLARK		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. 212-12-8902		17. INFORMANT Address MEMORIAL HOSPITAL-CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Pulmonary metastases (left lung) of carcinoma primary in left hand DUE TO (c) Chronic lymphocytic leukemia			INTERVAL BETWEEN ONSET AND DEATH 30 hours 8 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic lymphocytic leukemia			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct. 24, 1966 , to October 31, 1966 , that (I) (we) last saw the deceased alive on Oct. 31, 1966 , and that death occurred at 4:30 AM , from causes and on the date stated above.			
22a. SIGNATURE <i>Dr. Wyand F. Doerner, Jr.</i>		22b. DATE SIGNED 11-1-66	
22c. PHYSICIAN'S NAME (Type) DR. WYAND F. DOERNER, JR.		22d. ADDRESS 414 N. MECHANIC ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/2/66	23c. NAME OF CEMETERY OR CREMATORY Good Hope Cem.	23d. LOCATION (City or Town) (County) (State) near Barton, Allegany, Md.
24. FUNERAL DIRECTOR <i>W. Boul</i>		25a. REC'D BY REGISTRAR DATE NOV 4 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

13510

CERTIFICATE OF DEATH

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WYOMING

ALLERANY

CUMMINGS

GENERAL HOSPITAL

OCTOBER 11

MOORE

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STATE

WIFE

MALE

DECEASED

AGE 40

PA. 101, 10.

U.S.A.

CLARK

ALLERANY

GEORGE MOORE

21-12-1900 THE MORAL HOSPITAL-CUMMINGS, B.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13518

13511

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage		c. LENGTH OF STAY IN lb Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS RD#1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ambrose Middle Francis Last Morris		4. DATE OF DEATH Month October Day 5 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1896
9. AGE (In years lost birthday) yrs. 70		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) National, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ambrose Morris		14. MOTHER'S MAIDEN NAME Sarah Neus	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-10-2331	
17. INFORMANT Mrs. A.F. Morris		Address Mt. Savage, Maryland RD#1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized melanomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) primary melanoma of the skin DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 18 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug. 1 19 66 to Oct. 5 19 66 that (I) (we) last saw the deceased alive on Oct. 5 19 66 and that death occurred at 12 M. from the causes and on the date stated above.			
22a. SIGNATURE G. Paige Strong		22b. DATE SIGNED Oct. 6, 1966	
22c. PHYSICIAN'S NAME (Type) A. Paige Strong		22d. ADDRESS 167 E. Main St. Frostburg, Md.	
23a. BURIAL, CREMATION, or other disposition (Specify) Burial	23b. DATE THEREOF October 8, 1966	23c. NAME OF CEMETERY OR CREMATORY Wellersburg Cemetery	23d. LOCATION (City, town, or county) (State) Wellersburg, Somerset Co., Pa.
24. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Leegler		25a. REC'D BY REGISTRAR OCT 10 1966	
ADDRESS Hyndman, Pennsylvania		25b. REGISTRAR'S SIGNATURE Charles Judge	

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CERTIFICATE OF DEATH

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Memorial Hospital--DOA						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing d. STREET ADDRESS Jackson e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) MELVIN			First C			Middle MUNSON			Last 10/19/1966			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/2/1913		9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee Kelly Tire CO.				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Nikep, MD.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Joshua Munson						14. MOTHER'S MAIDEN NAME Elizabeth Jackson						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes War # 2				16. SOCIAL SECURITY NO.				17. INFORMANT Mrs. Helen Munson, Lonaconing, MD. Address (WIFE)				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis DUE TO (c) Coronary Sclerosis INTERVAL BETWEEN ONSET AND DEATH Sudden -----												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Lonaconing		20g. (County) Allegany		20h. (State) Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED October 19, 1966 Cumberland, Maryland ACTUAL SIGNATURE <i>Benedict Skitarelic</i> EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D. Address (Street, city, town, or county) Cumberland, Maryland												
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/23/1966		22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery				22d. LOCATION (City, town, or country) Moscow, MD.				
23. FUNERAL DIRECTOR GEORGE EICHHORN Address Lonaconing, MD.						24a. REC'D BY REGISTRAR OCT 21 1966 24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						

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CERTIFICATE OF DEATH

13513

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE West Virginia b. COUNTY Mineral	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b Ridgeley	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		d. STREET ADDRESS 16 Barncord St.	
3. NAME OF DECEASED (Type or print) First Hugh Middle Earnest Last Nester		4. DATE OF DEATH Month Oct. Day 2 Year 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 19, 1892
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 7 Days 14 Hours 14 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Work		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (County & State, or foreign country) Parsons, West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Albert Nester (Deceased)		14. MOTHER'S MAIDEN NAME Joretta Loughrie Nester (deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 705-10-6100	
17. INFORMANT Mrs. Ada Nester		Address 16 Barncord St. Ridgeley, W. Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Coronary Insufficiency DUE TO (c) Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Duodenal Ulcer			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/28 , 19 66 , to 10/2 , 19 66 ; that (I) (we) last saw the deceased alive on 10/2 , 19 66 , and that death occurred at 7 P. M., from causes and on the date stated above.			
22a. SIGNATURE Leo H. Ley, Jr.		22b. DATE SIGNED 10/3/66	
22c. PHYSICIAN'S NAME (Type) Dr. Leo H. Ley, Jr.		22d. ADDRESS N. Center St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/5/66	23c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cemetery	23d. LOCATION (City or Town) (County) (State) Fort Ashby Mineral W. Va.
24. FUNERAL DIRECTOR H. Wayne George		25a. REC'D BY REGISTRAR DATE OCT 5 1966	
ADDRESS Cumberland, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13213

UNITED STATES OF AMERICA

13213

RECEIVED
JAN 10 1964
U.S. DEPT. OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

CERTIFICATE OF DEATH

13514

Reg. Dist. No.

13516

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>ALLEGANY</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>LONA CONING</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>CRESAPTOWN</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>KYLE Nursing Home</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>ANNIE FOY PLATTER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>OCT 30 1966</u>			
S. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>SEPT 19, 1888</u>	
9. AGE last birthday <u>78</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MEYERSDALE, PA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>MARTIN FOY</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH CHRISTNER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or other) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>MR. WILLIAM PLATTER MEYERSDALE, PA</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Acute Myocardial Occlusion</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic CV Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
STATING UNDERLYING CAUSE LAST.							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>years</u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. at work at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1963</u> , to <u>OCT 30, 1966</u> , that I last saw the deceased alive on <u>OCT 28, 1966</u> , and that death occurred at <u>A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Samuel J. [Signature]</u> M.D.				ADDRESS (Street, city, town, state) <u>LONA CONING MD</u>		DATE SIGNED <u>10-30-66</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>NOV 2, 1966</u>		NAME OF CEMETERY OR CREMATORY <u>UNION CEMETERY</u>		LOCATION (City, town, or county) (State) <u>MEYERSDALE, Somer PA</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William [Signature]</u>		ADDRESS <u>325 MAIN ST MEYERSDALE, PA</u>	
DATE <u>NOV 3 1966</u>							

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55, 10M

13517

CERTIFICATE OF DEATH

13515

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b 20 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARGARET Middle S. Last PRICE		4. DATE OF DEATH Month OCT. Day 6th, Year 19 66	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 7th, 1898
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	11. IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOUSEWORK	
11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME EDWARD SHANNON		14. MOTHER'S MAIDEN NAME LOUISE ROBERTS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NONE		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT ANNAN PRICE, RFD 2, Box 95, FROSTBURG, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept , 19 66 to Oct , 19 66 that (I) (we) last saw the deceased alive on Oct 6 19 66 and that death occurred at 10/7/66 M, from causes and on the date stated above.			
22a. SIGNATURE John B. Davis, M.D.		22b. DATE SIGNED 10/7/66	
22c. PHYSICIAN'S NAME (Type) JOHN B. DAVIS,		22d. ADDRESS 2 BROADWAY, FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10-9-66	23c. NAME OF CEMETERY OR CREMATORY ECKHART CEMETERY	23d. LOCATION (City or Town) (County) (State) ECKHART, MD.
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR.		25a. REC'D BY REGISTRAR OCT 10 1966	
25b. REGISTRAR'S SIGNATURE <i>John B. Davis</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

class

FREE

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL

22

13518

13516

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE	
ALLEGANY		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
CUMBERLAND		FLINTSTONE Rt #2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
SACRED HEART HOSPITAL			
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last		Month Day Year	
(CHARLES) EDWARD RAINES		OCTOBER 20 1966	
5. SEX		6. COLOR OR RACE	
MALE		WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		3-20-84	
9. AGE (In years lost birthday) yrs.		IF UNDER 1 YEAR Months Days	
82		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Retired Dairyman			
11. BIRTHPLACE (Country & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
W.VA.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
MARTIN RAINES		CYNTHIA JANE HEDRICK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
No		220-48-0041	
17. INFORMANT		Address	
PT'S CHART			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) Coronary Heart Failure Atherosclerotic Heart Disease (c) Senility		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Urinary Tract Infection, severe			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/1/66, 1966, to 10/20, 1966, that (I) (we) last saw the deceased alive on 10/20 1966, and that death occurred at 6:14 PM, from causes and on the date stated above.			
22a. SIGNATURE		22b. DATE SIGNED	
DR. PAGAN, M.D.		10/20/66	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
DR. PAGAN, M.D.		Bridgeport, W. Va.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Burial		10/23/66	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Pleasant Grove Cemetery		Cumberland Allegany Maryland	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR	
Ruth E. Silcox Cumberland Maryland 21502		DATE OCT 25 1966	
		25b. REGISTRAR'S SIGNATURE	
		Charles Judge	

91261

21261

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and if any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13519

13517

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u>		c. LENGTH OF STAY IN lb <u>2 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hosp.</u>				d. STREET ADDRESS <u>901 Lafayette Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Raymond</u> Last <u>Ridgely</u>				4. DATE OF DEATH Month <u>October</u> Day <u>21</u> Year <u>19 66</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 5, 1927</u>	9. AGE (In years lost birthday) <u>39</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>01</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trucking Proprietor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking Business</u>		11. BIRTHPLACE (State or foreign country) <u>Ridgeley, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Walter Ridgely</u>				14. MOTHER'S MAIDEN NAME <u>Ida House</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes, W. W. # 2</u>		16. SOCIAL SECURITY NO. <u>213-22-2657</u>		17. INFORMANT <u>Mrs. Ida H. Ridgely</u> Address <u>901 Lafayette Ave. Cumb.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Coronary Sclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> -----	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						22. DATE SIGNED <u>10/21/66</u>	
ACTUAL SIGNATURE <u>Benedict Skitarolic</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Benedict Skitarolic, M. D.</u>		Address (Street, city, town, or county) <u>Rt. # 9 Cumberland, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/23/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Cumberland, Allegany Md.</u>	
24. FUNERAL DIRECTOR <u>H. Wayne George</u> <u>Cumberland, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 26 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

BP

1351

1351

COPIES WITH SIGNATURES

13520

CERTIFICATE OF DEATH

13518

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 1 HR.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. STREET ADDRESS RT. 5, BOX 201, CUMB.MD.	
3. NAME OF DECEASED (Type or print) First CARL Middle E. Last ROBINETTE		4. DATE OF DEATH Month OCTOBER Day 6 Year 1966	
5. SEX MALE XXXX	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1910 12-19-1910
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pump Room		10b. KIND OF BUSINESS OR INDUSTRY Textile Ind.	
11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME UPTON, ROBINETTE		14. MOTHER'S MAIDEN NAME Anna Dowling	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes war II		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus DUE TO (b) Auricular Fibrillation DUE TO (c) Right Bundle Branch Block			INTERVAL BETWEEN ONSET AND DEATH 1 yr. (?) (?)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Insufficiency, Myocardial Fibrosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug. 20, 19 64 , to Oct. 6, 19 66 , that (I) (we) last saw the deceased alive on Oct. 6, 19 66 , and that death occurred at 1 P. M, from causes and on the date stated above.			
22a. SIGNATURE <i>Dr. Samuel Jacobson</i>		22b. DATE SIGNED Oct. 7, 1966	
22c. PHYSICIAN'S NAME (Type) DR. SAMUEL JACOBSON		22d. ADDRESS 50 PERSHING ST.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 9, 1966	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR OCT 14 1966	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or disposal, and in any event, within 72 hours after death.

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13521

CERTIFICATE OF DEATH

13519

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE W. VA. b. COUNTY Mineral	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KEYSER	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 41 ORCHARD ST.	
3. NAME OF DECEASED (Type or print) First STELLA Middle ROBY Last ROBY		4. DATE OF DEATH Month 10 Day 18 Year 1966	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-25-90
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 23 Days 23 Hours 23 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired House Wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) W. VA. Petersburg.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ABRAHAM IMAN		14. MOTHER'S MAIDEN NAME Clara STUMP	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 234-70-1287	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis DUE TO (b) Small bowel intestinal obstruction DUE TO (c) Adenocarcinoma rectosigmoid			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-10-66 , 19 66 to 10-18- , 19 66 that (I) (we) last saw the deceased alive on 10-18- , 19 66 and that death occurred at 8:38 P.M. from causes and on the date stated above.			
22a. SIGNATURE DR. E. R. PAUL		22b. DATE SIGNED 10-19-66	
22c. PHYSICIAN'S NAME (Type) DR. E. R. PAUL		22d. ADDRESS 36 GREENE ST. CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-22-66	23c. NAME OF CEMETERY OR CREMATORY Queens Point Cem.	23d. LOCATION (City or Town) (County) (State) Keyser, W. Va. Mineral
24. FUNERAL DIRECTOR Thomas Smith Jr.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 24 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and return event within 72 hours after death.

VR A15ME (5)
6M 1/66

13522

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13520

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY in 1b. LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND 01-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA MEMORIAL HOSPITAL				d. STREET ADDRESS 815 ELMWOOD LANE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle P. Last ROEDER				4. DATE OF DEATH Month OCT. Day 24 Year 19 66			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 1, 1879		9. AGE (In years last birthday) yrs. 87		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUSINESS		10b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHRISTIAN ROEDER				14. MOTHER'S MAIDEN NAME KATHERINE SCHULTZ			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 215 16 4429		17. INFORMANT MRS. ANNA ROEDER Address CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) CORONARY SCLEROSIS DUE TO (c) ----							INTERVAL BETWEEN ONSET AND DEATH SUDDEN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		22. DATE SIGNED 10/24/66					
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		RT. 9, CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT. 27, 1966		23c. NAME OF CEMETERY OR CREMATORY ST. LUKES CEMETERY		23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.	
24. FUNERAL DIRECTOR BYRON KIGHT				ADDRESS CUMBERLAND, MD.		25a. REC'D BY REGISTRAR DATE OCT 31 1966	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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I, F. J.

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I, S.

13528

CERTIFICATE OF DEATH

13521

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b 7 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROUTE 1, FROSTBURG,	
3. NAME OF DECEASED (Type or print) First BARBARA Middle P. Last SAGAL		4. DATE OF DEATH Month OCTOBER Day 27th Year 19 66	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 6TH, 1882
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOUSEWORK	
11. BIRTHPLACE (County & State, or foreign country) HUNGARY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME PAUL PASTOR		14. MOTHER'S MAIDEN NAME ELIZABETH BALLA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 213-09-6515 A	
17. INFORMANT MRS. SUSAN ULTIS, MIDLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 Congestive heart failure DUE TO (b) arteriosclerotic C.V.D. DUE TO (c) years -		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 15, 19 66 to Oct 26, 19 66 that (I) (we) last saw the deceased alive on 27 Oct 19 66 , and that death occurred at 4:30 PM , from causes and on the date stated above.			
22a. SIGNATURE John B. Davis, M.D.		22b. DATE SIGNED 10/28/66	
22c. PHYSICIAN'S NAME (Type) JOHN B. DAVIS,		22d. ADDRESS 2 BROADWAY, FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-29-66	
23c. NAME OF CEMETERY OR CREMATORY F.B.G. MEMORIAL PARK		23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.	
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR.,		ADDRESS FROSTBURG, MD.	
25a. REC'D BY REGISTRAR DATE OCT 31 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

13524

CERTIFICATE OF DEATH

13522

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 9/10/66	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		d. STREET ADDRESS 235 Maryland Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Susan Middle R. Last Samuels		4. DATE OF DEATH Month October Day 17 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/11/1885
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Hedgesville, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Miles Riggleman		14. MOTHER'S MAIDEN NAME Angie Rohrbaugh	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT P.O.Box 599, Address Cumberland, Md. Allegany County Infirmary records.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis, chronic degenerative senile 4221 DUE TO arteriosclerosis, gangrene (b) concurrent - sigmoid DUE TO sub total deafness (c) Sub Total deafness Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/10/66 , 19 66 , to 10/17/66 , 19 66 that (I) (we) last saw the deceased alive on 10/17/66 , 19 66 , and that death occurred at A. M. from causes and on the date stated above.			
22a. SIGNATURE Lee B. Mathews		22b. DATE SIGNED 10/18/1966	
22c. PHYSICIAN'S NAME (Type) Lee B. Mathews, M. D.		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/20/66	
23c. NAME OF CEMETERY OR CREMATORY Philos		23d. LOCATION (City or Town) (County) (State) Westernport Md.	
24. FUNERAL DIRECTOR W. J. Boral		25a. REC'D BY REGISTRAR DATE OCT 20 1966	
ADDRESS Westernport, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

13584

RECORDS OF DEATH

13584

Allegany

Maryland

Allegany

Gender

Age

Residence

Allegany County, Maryland

235 Maryland Ave.

Sex

Birth

Death

Male

1/1/1905

81

House

Miss Richard

Miss Richard

Allegany County, Maryland records.

10/1/05

10/1/05

10/1/05

Mr. E. Mathews, N. D.

Mr. E. Mathews, N. D.

Death

Birth

Death

Residence

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13525

CERTIFICATE OF DEATH

13523

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 4 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle R. Last SEIBERT		4. DATE OF DEATH Month OCTOBER Day 28 Year 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-11-95
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED GRINER		10b. KIND OF BUSINESS OR INDUSTRY STEEL CO.	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME WILLIAM R. SEIBERT		14. MOTHER'S MAIDEN NAME MAGGIE ORNDOFF	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-05-8935	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Aneurysm 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Cerebral Vascular Disease DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 72 hrs 12 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Cumby, Allegany, Md	
21. I certify that (I) (this hospital) attended the deceased from 10/27/66 , to 10/28/66 , that (I) (we) last saw the deceased alive on 10/27/66 , and that death occurred at 6:50 PM , from causes and on the date stated above.			
22a. SIGNATURE Dr. R. J. Williams		22b. DATE SIGNED 10/27/66	
22c. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS		22d. ADDRESS 122 S. CENTRE ST.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT. 31, 1966	
23c. NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL PARK		23d. LOCATION (City or Town) (County) (State) CUMBERLAND ALLEGANY MD.	
24. FUNERAL DIRECTOR BYRON KIGHT		25a. REC'D BY REGISTRAR NOV 7 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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ALL GARY

MARYLAND

CUMBERLAND

ADA

CUMBERLAND

RT. 3, BEDFORD RD.

MEMORIAL HOSPITAL

SEIBERT

WILLIAM

4-11-92

WHITE

MARYLAND

JACQUE GRONOFF

WILLIAM E. SEIBERT

MEMORIAL HOSPITAL, CUMBERLAND, MD.

13557, CENTRE ST.

WILLIAM E. J. WILLIAMS

NOV 19 1992

11/19/92

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13526

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13524

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 73 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D. O. A. Memorial Hospital		e. STREET ADDRESS 58 Wempe Drive	
3. NAME OF DECEASED (Type or print) First Norene Middle Amanda Last Sellers		4. DATE OF DEATH Month Oct. Day 6 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 23, 1893
9. AGE (In years last birthday) 73		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William H. Rice		14. MOTHER'S MAIDEN NAME Cora J. Golden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Homer N. Sellers, Cumberland, Md.		Address Husband	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO 4201 CORONARY SCLEROSIS (b) --- DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, M.D.		22. DATE SIGNED Oct. 6, 1966	
Address (Street, city, town, or county) Rt. 9 Cumberland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 8, 1966	23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	23d. LOCATION (City or Town) (County) (State) Cumberland, Md. - Allegany
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR OCT 14 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

13527

CERTIFICATE OF DEATH

13525

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 8/11/1960	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 117 Mary Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Willie Middle Paige Last Shank		4. DATE OF DEATH Month October Day 27 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 4/11/1898
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Greenspring, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Raymond Wilson		14. MOTHER'S MAIDEN NAME Effie Bennington	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-22-4346T	
17. INFORMANT P.O. Box 599, Cumberland, Md.		18. Allegany County Infirmary records.	
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive ch. degenerative DUE TO arteriosclerosis, general vascular DUE TO hypertension DUE TO Parkinson's disease - Central Nervous System Syphilis (c) 026X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/11/60 , 19__, to 10/27/66 , 19__, that (I) (we) last saw the deceased alive on 10/26/66 , 19__, and that death occurred at A. M. , from causes and on the date stated above.			
22a. SIGNATURE Lee B. Mathews		22b. DATE SIGNED 10/27/1966	
22c. PHYSICIAN'S NAME (Type) Lee B. Mathews, M. D.		22d. ADDRESS 49 Greene St, Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 30, 1966	
23c. NAME OF CEMETERY OR CREMATORY Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Springfield, W. Va.	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE OCT 31 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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Figure 2

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REFERENCES

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BUREAU OF ECONOMIC ANALYSIS

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13528

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) "Rural" Barton				c. LENGTH OF STAY IN 1b "Rural" Barton			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Shaw Last Shaw				4. DATE OF DEATH Month October Day 4 Year 19 66			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 14, 1899		9. AGE (In years last birthday) 67 yrs.	10. IF UNDER 1 YEAR Months 4 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Barton, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Gowans				14. MOTHER'S MAIDEN NAME Jean Lees			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Walter Shaw		Address Moscow, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis - severe DUE TO (c) years						INTERVAL BETWEEN ONSET AND DEATH 4 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1966 , to Oct 4, 1966 , that (I) (we) last saw the deceased alive on Oct 4, 1966 , and that death occurred at 3:30 PM , from causes and on the date stated above.							
22a. SIGNATURE L. R. MILES, JR.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10.6.66	
22c. PHYSICIAN'S NAME (Type) L. R. MILES, JR. MD				22d. ADDRESS LONA CONING MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/7/66		23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Moscow, A. Md	
24. FUNERAL DIRECTOR George Eichhorn				ADDRESS Lonaconing, Md.		25a. REC'D BY REGISTRAR DATE OCT 7 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

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VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13529

CERTIFICATE OF DEATH

13527

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN lb 14 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS ROSEWOOD AVE., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First CLARENCE Middle C Last SHINHOLT		4. DATE OF DEATH Month OCT. Day 10 Year 66				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 8, 1908	9. AGE (In years Last birthday) 57 yrs.	IF UNDER 1 YEAR Months 37	IF UNDER 24 HRS. Days 19 Hours 57 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME LEWIS SHINHOLT			14. MOTHER'S MAIDEN NAME Ella Groves			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 705-05-4764		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD. Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema - Heart Failure 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cirrhosis of Liver DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 4 days years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral Edema - Renal Insufficiency						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1955-05-19 A, to 1966 , 19, that (I) (we) last saw the deceased alive on 10/9 , 19 66 and that death occurred at 10/14/66 M, from causes and on the date stated above.						
22a. SIGNATURE DR. G. OVERTON HIMMELWRIGHT		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/14/66		
22c. PHYSICIAN'S NAME (Type) DR. G. OVERTON HIMMELWRIGHT		22d. ADDRESS 133 VIRGINIA AVE., CUMBERLAND, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 12, 1966		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany
24. FUNERAL DIRECTOR James . Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR DATE OCT 13 1966		25b. REGISTRAR'S SIGNATURE Charles Judge

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CERTIFICATE OF DEATH

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MEMORIAL HOSPITAL, CUMBERLAND, MD.



DR. G. G. G. G. G.

DR. G. G. G. G. G.

13530

CERTIFICATE OF DEATH

13528

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 4/1/1965	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		d. STREET ADDRESS 305 Grand Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last Flora Estella Smith		4. DATE OF DEATH Month Day Year October 2, 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/2/1894
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Great Cacapon, West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Wesley Farris		14. MOTHER'S MAIDEN NAME Elizabeth Hofs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT P.O. Box 599 Address Cumberland, Md.		Allegany County Infirmary records.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 DUE TO ① Myocardial infarction, etc. degenerative Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. ② Arteriosclerosis, general & cerebral - DUE TO ③ Cerebral apoplexy, & at Haversian plexia (c) Cerebral apoplexy, & at Haversian plexia			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/1/1965 , 19__, to 10/2/66 , 19__, that (I) (we) last saw the deceased alive on 10/1/1966 19__, and that death occurred at P. M. , from causes and on the date stated above.			
22a. SIGNATURE Lee B. Mathews		22b. DATE SIGNED 10/3/1966	
22c. PHYSICIAN'S NAME (Type) Lee B. Mathews, M. D.		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10- 5-66	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	23d. LOCATION (City or Town) (County) (State) Cumberland, Md.
24. FUNERAL DIRECTOR James F. Scarpelli Cumberland, d.		25a. REC'D BY REGISTRAR DATE OCT 10 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1370

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13531

CERTIFICATE OF DEATH

13529

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 5 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CORRIGANVILLE		d. STREET ADDRESS 01-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARVEY Middle J. Last SMITH, Jr.		4. DATE OF DEATH Month OCT. Day 9, Year 19 66	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-17-1931 34 yrs last birthday
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) MARYLAND
13. FATHER'S NAME HARVEY SMITH		14. MOTHER'S MAIDEN NAME Bortha E. HOSSELRODE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-28--9342	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive and arteriosclerotic CVD DUE TO (c) Diabetes mellitus, severe, with acidosis		INTERVAL BETWEEN ONSET AND DEATH 24 hours years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Gastritis or ulcer with hemorrhage and anemia. Uremia.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 4th , 19 66 , to Oct. 9th , 19 66 , that (I) (we) last saw the deceased alive on Oct. 9th , 19 66 , and that death occurred at 7:00 PM from causes and on the date stated above.			
22a. SIGNATURE <i>Dr. W. F. Doerner, Jr.</i>		22b. DATE SIGNED 10-11-66	
22c. PHYSICIAN'S NAME (Type) DR. W. F. DOERNER, Jr.		22d. ADDRESS 414 N. MECHANIC ST.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct..12, 1966	
23c. NAME OF CEMETERY OR CREMATORY White Oaks Cemetery		23d. LOCATION (City or Town) (County) (State) Meyersdale, Pa. Somerset Co. PA#1	
24. FUNERAL DIRECTOR <i>Harvey H. Feigler, Hyndman, Pa.</i>		25a. REC'D BY REGISTRAR DATE OCT 17 1966	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

1353

ESTIMATE OF DEATH

1353

NAME WHITE		SURNAME SMITH	
DATE 10-11-1911		PLACE MARYLAND	
SEX MALE		OCCUPATION LABORER	
AGE 30		HEIGHT 5' 10"	
WEIGHT 160		BUILD MEDIUM	
COMPLEXION FAIR		EYES BLUE	
HAIR BROWN		TEETH GOOD	
MARRIAGE SINGLE		EDUCATION HIGH SCHOOL	
RELIGION METHODIST		SERVICE NONE	
PRESENT ADDRESS 1234 MAIN ST., BALTIMORE, MD.		PLACE OF BIRTH BALTIMORE, MD.	
OCCUPATION LABORER		EMPLOYER BALTIMORE & ANNE ARDELL RAILROAD CO.	
DATE OF DEATH 10-11-1911		PLACE OF DEATH BALTIMORE, MD.	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
SIGNATURE OF PHYSICIAN J. H. MCGRAW, M.D.		SIGNATURE OF WITNESSES J. H. MCGRAW, M.D.	
SIGNATURE OF DEATH REGISTRAR J. H. MCGRAW, M.D.		SIGNATURE OF CLERK J. H. MCGRAW, M.D.	

13532

CERTIFICATE OF DEATH

13530

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b Years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Rural		01.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		d. STREET ADDRESS Route #2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Virginia G. Snider		4. DATE OF DEATH Month Day Year 10 18 19 66	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/28/00
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Amar Wilson		14. MOTHER'S MAIDEN NAME Ida Bell Middleton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-03-7284	
17. INFORMANT patient's chart Leroy Snider RD2, Cumberland		Address Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of vulva with 1760 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized metastases DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January , 19 60 , to 04/18 , 19 66 , that (I) (we) last saw the deceased alive on 04/18 , 19 66 and that death occurred at 10/18/66 M, from causes and on the date stated above.			
22a. SIGNATURE B M. Schindler		22b. DATE SIGNED 10/18/66	
22c. PHYSICIAN'S NAME (Type) B M. Schindler		22d. ADDRESS 43 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 21, 1966	
23c. NAME OF CEMETERY OR CREMATORY Mt. Herman Cemetery		23d. LOCATION (City or Town) (County) (State) Near Cumberland, Allegany Md.	
24. FUNERAL DIRECTOR John J. Hafer		25a. REC'D BY REGISTRAR John J. Hafer	
25b. REGISTRAR'S SIGNATURE John J. Hafer		25c. DATE OCT 21 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1994

6261

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13532

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13531

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CUMBERLAND		c. LENGTH OF STAY IN lb 1 DAY	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) FAIRGO			d. STREET ADDRESS 206 DECATUR STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First PETER Middle M. Last SOTIROKOS			4. DATE OF DEATH Month OCT. Day 31 Year 19 66		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH UNKNOWN	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STORE OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY CANDY STORE		11. BIRTHPLACE (State or foreign country) GREECE	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME MICHAEL SOTIROKOS		
14. MOTHER'S MAIDEN NAME PANAGIOTA BERGERAS			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		
16. SOCIAL SECURITY NO. UNKNOWN			17. INFORMANT MRS. GEORGE PARSENIOS Address CUMBERLAND, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY THROMBOSIS DUE TO (c) CORONARY SCLEROSIS					INTERVAL BETWEEN ONSET AND DEATH SUDDEN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Benedict Skitarulic		M.D.		22. DATE SIGNED November 1, 1966	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		RT. 9		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF NOV. 3, 1966	23c. NAME OF CEMETERY OR CREMATORY ZION MEMORIAL PARK		23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.	
24. FUNERAL DIRECTOR BYRON KIGHT			25a. REC'D BY REGISTRAR DATE NOV 7 1966		
ADDRESS CUMBERLAND, MD.			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

18881

18881

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

125324

13532

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RAWLINGS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL			d. STREET ADDRESS RD# 3 BOX 56		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JOHN Middle E. Last STAGGS			4. DATE OF DEATH Month OCTOBER Day 8 Year 1966		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-23-99		9. AGE (In years lost birthday) yrs. 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Textile		10b. KIND OF BUSINESS OR INDUSTRY Textile		11. BIRTHPLACE (State or foreign country) W. VA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME John W. Staggs		
14. MOTHER'S MAIDEN NAME Ida Dawson			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		
16. SOCIAL SECURITY NO. 214 07 1631		17. INFORMANT PT'S CHART			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY SCLEROSIS (c) -----					INTERVAL BETWEEN ONSET AND DEATH HOURS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		M.D.		22. DATE SIGNED October 8, 1966	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12 Oct 1966		23c. NAME OF CEMETERY OR CREMATORY Dawson	
24. FUNERAL DIRECTOR <i>Robert M. Rotruck</i>		ADDRESS Keyser, W. Va.		25a. REC'D BY REGISTRAR DATE OCT 17 1966	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

13534

13534

Textile

Textile

John W. Dawson

John W. Dawson

City of New York

NY

13 Oct 1988 Dawson

Keyser, J. W.

13 Oct 1988

NY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please re-attach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Item #9 Film #G382 10/28/66 pc

CERTIFICATE OF DEATH

13535

13533

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 8/15/1966	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 711 Gephart Drive	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Catherine Theresa Stull		4. DATE OF DEATH Month October Day 19 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/3/1882
9. AGE (In years at birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Hazleton, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edward McGrady		14. MOTHER'S MAIDEN NAME Mary Carr	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O. Box 599, Cumberland, Md.		Allegany County Infirmary records.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① Regenerative, Chn. degenerative DUE TO (b) ② Arterio Sclerosis, General + cerebral DUE TO (c) ③ Bilateral Cataracts (left operated)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/15/66 , 19__, to 10/19/66 , 19__, that (I) (we) lost saw the deceased alive on 10/18/66 , 19__, and that death occurred at A. M. from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 10/19/1966	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10/22/66	St. Peter + Paul	Cumberland Md
24. FUNERAL DIRECTOR Louis Stein Inc. Cumb. Md.		25a. REC'D BY REGISTRAR DATE OCT 24 1966	
ADDRESS		25b. REGISTRAR'S SIGNATURE [Signature]	

13533

13533

Allegany

Allegany

Allegany

Concordland

8/15/1966

Concordland

711 Republic Drive

Allegany County Jail

17, 1966

State

Concordland

17, 1966

8/15/1966

X

For sale

Hanover, Pennsylvania, U. S. A.

Harry G. Galt

Edward McGarry

100 Box 299, Concordland, N.Y.
Allegany County Jail

10/13/66

8/15/66

10/13/66

at 7:30 A.M.

10/13/66

10/13/66

1M
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute a certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13536

13534

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 10 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 637 Lincoln Street	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last George Preston Sullivan				4. DATE OF DEATH Month Day Year October 17 19 66			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 7, 1880		9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Accountant- WM Railroad		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Danville, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Sullivan				14. MOTHER'S MAIDEN NAME Hallie Preston			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 705-10-5586		17. INFORMANT Earl R. Sullivan		Address 637 Lincoln Street Cumberland, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Vascular Disease (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 10 Days -----	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED October 17, 1966	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Cumberland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/19/66	22c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran Cemetery		22d. LOCATION (City, town, or country) Cumberland Allegany Maryland		(State)	
23. FUNERAL DIRECTOR ADDRESS Ruth E. Silcox Cumberland Maryland 21502				24a. REC'D BY REGISTRAR DATE OCT 19 1966			
				24b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>			

MEDICAL CERTIFICATION

13233

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
13535										
1. PLACE OF DEATH a. COUNTY Allegany					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport			c. LENGTH OF STAY IN 1b 61 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wood St. Ext.					d. STREET ADDRESS Wood St. Ext.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Harley Middle Sylvester Last Tasker					4. DATE OF DEATH Month Oct. Day 14 Year 1966					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 31, 1883		9. AGE (In years last birthday) 82 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (County & State, or foreign country) W. Va.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Louis Tasker					14. MOTHER'S MAIDEN NAME Susan "Tasker"					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. (If give war or dates of service)		17. INFORMANT Mrs. Robert Miller			Address Westernport, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular hemorrhage 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH 20 min		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1964 , 19____, to 10-14 , 19 66 , that (I) (we) last saw the deceased alive on 10-14 , 19 66 , and that death occurred at 12:19 PM , from the causes and on the date stated above.										
22a. SIGNATURE Robert Bess Jr.					22b. DATE SIGNED M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) Robert Bess Jr.					22d. ADDRESS Ashfield St., Piedmont, W. Va.					
23a. BURIAL, CREMATION, or other disposition (Specify) Burial			23b. DATE THEREOF Oct. 16, 1966		23c. NAME OF CEMETERY OR CREMATORY Philos Cem.		23d. LOCATION (City, town or county) (State) Westernport, Md.			
24. FUNERAL DIRECTOR Charles Judge					ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR DATE OCT 17 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13538

CERTIFICATE OF DEATH

13536

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Cumberland</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Cumberland MD</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>RFD # 2 Route 40 East</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>W.</u> Middle <u>Russell</u> Last <u>Thayer</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>25</u> Year <u>1966</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 30 1893</u>		9. AGE (In years last birthday) <u>73</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Superintendent U.S. Post Office</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Rowlesburg W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles W. Thayer</u>				14. MOTHER'S MAIDEN NAME <u>Ella Wheeler</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs. W. Russell Thayer</u> Address <u>Cumb MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left ventricular failure</u> <u>443X</u> DUE TO (b) <u>Arteriosclerotic and hypertensive CVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Uremia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>3 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4 - 14 - 19 53</u> to <u>10-25 - 19 66</u> , that (I) (we) last saw the deceased alive on <u>10 - 20 19 66</u> , and that death occurred at <u>1a</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Ralph W. Ballin</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10-26-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ralph W. Ballin, M.D.</u>				22d. ADDRESS <u>62 Greene St. Cumberland, Md. 21502</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/27/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Cumberland MD</u>	
24. FUNERAL DIRECTOR <u>Louis Stein Inc. Cumb. MD</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 28 1966</u>			
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13539		13537	
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. LENGTH OF STAY IN 1b Lonaconing	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Seldom Seen Road		d. STREET ADDRESS Seldom Seen Road	
3. NAME OF DECEASED (Type or print) First Hettie Middle Mary Last Timney		4. DATE OF DEATH Month October Day 14 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/15/1885
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 01 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Moscow, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry H. Warnick		14. MOTHER'S MAIDEN NAME Mary Dawson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Mary Cooper		Address Lonaconing, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Ischemia DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Atherosclerotic CV disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1966 to Oct 14, 1966 that (I) (we) last saw the deceased alive on Sept 19, 1966 , and that death occurred at PM , from causes and on the date stated above.			
22a. SIGNATURE L. R. Miles, Jr.		22b. DATE SIGNED 10.17.66	
22c. PHYSICIAN'S NAME (Type) L. R. MILES, JR., M.D.		22d. ADDRESS LONA CONING MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/17/66	
23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Moscow A. Md	
24. FUNERAL DIRECTOR George Eichhorn		25a. REC'D BY REGISTRAR DATE OCT 19 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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STATE OF NEW YORK

Allegany

Maryland

Allegany

Donnacona

Donnacona

Salmon River Road

Salmon River Road

Timothy J. Cooper

Harry Kettie

1/15/1885

Female White

Moscow, Maryland

None

Mary Lawson

Henry H. Varrick

Mrs. Mary Cooper
Donnacona, Md.

Moscow

Latent Hill Cemetery

10/11/00

trial

Donnacona, Md.

George Nicholson

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13540

CERTIFICATE OF DEATH

13538

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN lb 3 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LONA CONING, d. STREET ADDRESS 22 ROCKVILLE ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY ANN TRULY		4. DATE OF DEATH 10-27 19 66					
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-19-1876	9. AGE (In years (at birthday) yrs.) 89	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) LONA CONING, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME THOMAS DICK			14. MOTHER'S MAIDEN NAME MARGARET SCHUYLER				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Sclerosis C. V. D.</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>(Sudden death)</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-24-66 to 10-27-66, that (I) (we) last saw the deceased alive on 10-27-66 and that death occurred at 8:45 PM from causes and on the date stated above.							
22a. SIGNATURE <u>Wm. F. Williams</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-28-66			
22c. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS		22d. ADDRESS 122 S. CENTRE ST.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/30/66		23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Lonaconing A. Md	
24. FUNERAL DIRECTOR George Eichhorn		ADDRESS Lonaconing, Md.		25a. REC'D BY REGISTRAR DATE OCT 31 1966		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. If possible, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #230 & d Film #G382 10/26/66 pc

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	c. LENGTH OF STAY IN lb 1 DAY	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. STREET ADDRESS BOX 1065	f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First GEORGE Middle E Last WAGNER		4. DATE OF DEATH Month 10 Day 15 Year 19 66	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-24-1902
9. AGE (In years, do not birthday yrs.) 64		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) SALISBURY, PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM WAGNER		14. MOTHER'S MAIDEN NAME BARBARA JOHNSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WAR # 2		16. SOCIAL SECURITY NO. 172-18-0728	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Coronary Artery Disease DUE TO (c) Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cholesterol Arteriosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Camp, Alleg. Md.		20f. (City or town) (County) (State) Salisbury Pa.	
21. I certify that (I) (this hospital) attended the deceased from 1/2/62 , 19__, to 10/15/66 , 19__, that (I) last saw the deceased alive on 10/15/66 , 19__, and that death occurred at 10 PM from causes and on the date stated above.			
22a. SIGNATURE DR. R.J. WILLIAMS		22b. DATE SIGNED 10/17/66	
22c. PHYSICIAN'S NAME (Type) DR. R.J. WILLIAMS		22d. ADDRESS 122 S CENTRE ST. CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-18-66	
23c. NAME OF CEMETERY OR CREMATORY Moversdale Union Cemetery Salisbury, Pa.		23d. LOCATION (City or town) (County) (State) Salisbury Somerset Pa.	
24. FUNERAL DIRECTOR Stanley M Thomas Salisbury Pa		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 21 1966	

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CERTIFICATE OF DEATH

James Henry Jones
James Henry Jones

James Henry Jones

James Henry Jones
James Henry Jones

James Henry Jones
James Henry Jones

FOR STATE HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13540

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN lb 24 HOURS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FLINTSTONE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS STAR ROUTE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BESSIE FRANCES WEIMER			4. DATE OF DEATH Month Day Year OCTOBER 30 19 66				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 9, 1905		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JACOB W. WHITACRE			14. MOTHER'S MAIDEN NAME EMILY ALICE SEATON				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PERICARDITIS, DUE TO (b) BRONCHOGENIC CARCINOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)						INTERVAL BETWEEN ONSET AND DEATH DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED October 30, 1966 Address (Street, city, town, or county) Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF NOV. 2, 1966		23c. NAME OF CEMETERY OR CREMATORY MT. SAVAGE METHODIST CEM.		23d. LOCATION (City or Town) (County) (State) MT. SAVAGE, ALLEGANY, MD.	
24. FUNERAL DIRECTOR JOHN J. HANER, 230 BALTO. AVE, CUMBERLAND, MD.				25a. REC'D BY REGISTRAR DATE NOV 2 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

13340

13340

FOR STATE
HEALTH DEPT.

13542

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13541

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>52 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D. O. A. Memorial Hospital</u>			d. STREET ADDRESS <u>216 Wempe Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Franklin</u> Last <u>Weltman</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>30</u> Year <u>1966</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 31, 1914</u>	9. AGE (In years last birthday) yrs. <u>52</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>George F. Weltman</u>		
14. MOTHER'S MAIDEN NAME <u>Florence Trout</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		
16. SOCIAL SECURITY NO. <u> </u>			17. INFORMANT Address <u>Mrs. Catherine Weltman, Cumberland, Md.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> <u>CORONARY OCCLUSION</u> DUE TO (b) <u>CORONARY THROMBOSIS</u> DUE TO (c) <u>CORONARY SCLEROSIS</u>					INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. Benedict Skitarelic, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Oct. 30, 1966 22. DATE SIGNED			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <u>Rt. 9 Cumberland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 2, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Cumberland, Md. Allegany</u>		
24. FUNERAL DIRECTOR <u>James F. Scarpelli, Cumberland, Md.</u>			25a. REC'D BY REGISTRAR DATE <u>NOV 3 1966</u>		
			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

3662

1356

CERTIFICATE OF DEATH

13544

13542

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 7 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 527 PATTERSON AVENUE	
3. NAME OF DECEASED (Type or print) First HOMER Middle L. Last WILLIAMS		4. DATE OF DEATH Month OCTOBER Day 11 Year 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-2-1900
9. AGE (In years lost birthday) yrs. 66		IF UNDER 1 YEAR Months 00 Days 00 Hours 00 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Auditor- Fort Cumberland Hotel		10b. KIND OF BUSINESS OR INDUSTRY CUMBERLAND, MD.	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY WILLIAMS		14. MOTHER'S MAIDEN NAME JANE PHILLIPS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 211-05-4635	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia for advanced 5271 DUE TO a. Emphysema for advanced Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Coronary artery disease marked DUE TO (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Since 11-6-59		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-6-1959 to 10-11-1966 that (I) (we) last saw the deceased alive on 10-10-1966 and that death occurred at 1:05 A.M. from causes and on the date stated above.			
22a. SIGNATURE W. F. Williams M.D.		22b. DATE SIGNED 10-11-66	
22c. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS		22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/13/66	
23c. NAME OF CEMETERY OR CREMATORY Queen's Point Cemetery		23d. LOCATION (City or Town) (County) (State) Keyser Mineral W. Va.	
24. FUNERAL DIRECTOR H. Lee Silcox		25a. REC'D BY REGISTRAR Cumberland Maryland 21502	
25b. REGISTRAR'S SIGNATURE DATE OCT 13 1966			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13566

TESTIMONY OF DEATH

13566

ALLEGANY

MARY AND

ALLEGANY

CUMBERLAND

5 DAYS

CUMBERLAND

MEMORIAL HOSPITAL

237 PATTERSON AVENUE

HOMER

WILLIAMS

DOCTOR

WAGE WHITE

1-2-1900

CUMBERLAND, MD.

HENRY WILLIAMS

DAVE PHILLIPS

MEMORIAL HOSPITAL - CUMBERLAND, MD.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

BB

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13545

CERTIFICATE OF DEATH

13543

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN Ib 8/22/1961	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		d. STREET ADDRESS 537 N. Centre St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Melissa Middle Daisy Last Williams		4. DATE OF DEATH Month October Day 11 , 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/1/1882
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) Cumberland, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Edward Schilling		14. MOTHER'S MAIDEN NAME Barbara Dollhopf	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O.Box 599, Cumberland, Md.		Allegany County Infirmary records.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (1) Myocarditis, Cholelithiasis DUE TO (2) Arterio Sclerosis & Hypertension DUE TO (3) Splanchnic Arteries Thrombosis & DUE TO (4) Rupture of Aorta DUE TO (5) Myocardial Infarction DUE TO (6) Hemorrhage (Brain) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/22/61 , 19__, to 10/11/66 , 19__, that (I) (we) last saw the deceased alive on 10/10/66 , 19__, and that death occurred at A. M., from causes and on the date stated above			
22a. SIGNATURE L. B. Mathews		22b. DATE SIGNED 10/11/1966	
22c. PHYSICIAN'S NAME (Type) L. B. Mathews, M. D.		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/13/66	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.
24. FUNERAL DIRECTOR H. Wayne George		25. REC'D BY REGISTRAR OCT 14 1966	
25a. REGISTRAR'S SIGNATURE Charles Judge			

13545

Allegany

Comberland

8/22/1901

Comberland

Allegany County In history

237 N. Centre St.

William

Deary

Williams

Deary

Deary

White

White

10/1/1882

10/1/1882

Housewife

Edward Schilling

Barbara Schilling

Comberland, Maryland

U. S. A.

Allegany County history records

Joe B. Mathews, N. D.

Joe B. Mathews, N. D.

Oct 11 1901

TO HOSPITAL & ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13546											
13544											
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 315 OLDTOWN ROAD						d. STREET ADDRESS 315 OLDTOWN ROAD					
3. NAME OF DECEASED (Type or print) First Middle Last ALLEDA B. WILSON						4. DATE OF DEATH Month Day Year OCT. 16 19 66					
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 18, 1895		9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME				11. BIRTHPLACE (County & State, or foreign country) BARTON, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM BOAL						14. MOTHER'S MAIDEN NAME MARILDA SCHRAMM					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address MRS. NOVELLA DAVIS, PIEDMONT, W. VA.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC FAILURE 1533 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) Carcinomatosis from DUE TO (c) Cancer of sigmoid colon INTERVAL BETWEEN ONSET AND DEATH 10 days 6 months 11											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 4/10 1966 to 10/16 1966 that (I) (we) last saw the deceased alive on 10/15 1966 and that death occurred at 4 AM from the causes and on the date stated above.											
22a. SIGNATURE Thomas F Lewis M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) THOMAS F LEWIS						22d. ADDRESS 500 GREEN ST, CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Oct. 19, 1966		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		23d. LOCATION (City, town or county) (State) CUMBERLAND, MD.					
24. FUNERAL DIRECTOR'S SIGNATURE Byron Reglet ADDRESS CUMBERLAND, MD.						25a. REC'D BY REGISTRAR OCT 24 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

1853

ENTRANCE OF DEATH

1853

1853

1853

1853

1853

OCT 18 1853

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13547

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13545

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN lb 60 YEARS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 803 BEDFORD ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BRUCE Middle WILSON Last WILSON			4. DATE OF DEATH Month OCT. Day 18 Year 19 66				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 11, 1881		9. AGE (In years lost birthday) 85 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONTRACTOR		10b. KIND OF BUSINESS OR INDUSTRY HOME BUILDING		11. BIRTHPLACE (State or foreign country) MARYLAND			
13. FATHER'S NAME ISAAC WILSON			14. MOTHER'S MAIDEN NAME CATHERINE ASH				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214 32 2923		17. INFORMANT LEO WILSON Address CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Skull Fracture DUE TO (c) Arteriosclerotic Cardiovascular Disease					INTERVAL BETWEEN ONSET AND DEATH 1 Day 1 Day		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Cardiovascular Disease					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell while standing on Sidewalk					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 10:00 Oct. 17 19 66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street			
		20f. (City or town) Cumberland, Allegany, Maryland		(County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: XXXXXX Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
		Address (Street, city, town, or county) RT. 9 CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT. 21, 1966		23c. NAME OF CEMETERY OR CREMATORY HILLCREST BURIAL PARK			
				23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.			
24. FUNERAL DIRECTOR BYRON KIGHT		ADDRESS CUMBERLAND, MD.		25a. REC'D BY REGISTRAR DATE OCT 24 1966			
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. SAVAGE	c. LENGTH OF STAY IN lb LIFE	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. SAVAGE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CHURCH HILL		d. STREET ADDRESS CHURCH HILL	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last MARY T. WITTE		4. DATE OF DEATH Month Day Year OCT. 18 19 66	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 14, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL TEACHER		10b. KIND OF BUSINESS OR INDUSTRY PUBLIC SCHOOLS	9. AGE (In years lost birthday) yrs. 73
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LOUIS E. WITTE		14. MOTHER'S MAIDEN NAME CATHERINE O'CALLAHAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 212 38 7391	
17. INFORMANT ELIZABETH WITT		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY SCLEROSIS DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH SUDDEN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D. EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED OCT. 18, 1966	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF OCT. 21, 1966	23c. NAME OF CEMETERY OR CREMATORY ST. PATRICKS CEMETERY	23d. LOCATION (City or Town) (County) (State) MT. SAVAGE, MD.
24. FUNERAL DIRECTOR BYRON KIGHT		ADDRESS CUMBERLAND, MD.	
25a. REC'D BY REGISTRAR DATE OCT 24 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LITTLE ORLEANS		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOME		d. STREET ADDRESS LITTLE ORLEANS MD.	
3. NAME OF DECEASED (Type or print) First NOAH Middle K Last YONKER		4. DATE OF DEATH Month 10 Day 3 Year 1966	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12.21.1875
9. AGE (In years last birthday) yrs. 90		10. IF UNDER 1 YEAR Months 3 Days 19 Hours 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) ALLEGANY COUNTY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MARTIN V YONKER		14. MOTHER'S MAIDEN NAME MARY A DENEEN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT DELMER YONKER LITTLE ORLEANS MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary sclerosis DUE TO (c) Semi plegia		INTERVAL BETWEEN ONSET AND DEATH 3 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from APRIL , 19 63 , to 10.2. , 19 66 , that (I) (we) last saw the deceased alive on 10.2 , 19 66 and that death occurred at 3.30M , from causes and on the date stated above.			
22a. SIGNATURE <i>W. Spapper</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Hancock Md.</i>		22d. ADDRESS <i>Hancock Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10.7.66	23c. NAME OF CEMETERY OR CREMATORY PINEY PLAINS	23d. LOCATION (City or Town) (County) (State) LITTLE ORLEANS ALLEGANY MD.
24. FUNERAL DIRECTOR <i>Howard & Marie Hancock Md.</i>		25a. REC'D BY REGISTRAR DATE OCT 10 1966	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARTIN V. ROYER

MARTIN V. ROYER

DELIVER TO THE LITTLE ROCK OFFICE

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